ABSTRACT OF THE

Lettsomian Lectures

ON

SELECTED SUBJECTS IN THE SURGERY OF INFANCY AND CHILDHOOD.

Delivered at the Medical Society of London on Jan. 6th, 1890,

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LECTURE I.

THE TREATMENT OF ENLARGED GLANDS.

AFTER some introductory remarks the lecturer said that for a branching scar upon the neck of a child, the result of abscesses in the cervical glands, someone, not the child, might be held worthy of blame. Sometimes it might be the parents who were to blame, in that they neglected to seek professional advice when the disease was appearing in a mild and manageable form; or who, having obtained skilled advice, declined to be guided by it. Frequently the blame rested with the medical attendant himself. Often he had the opportunity of watching and treating the case from its very beginning, but it had gone on so slowly and quietly that he found it an easy and convenient matter to adopt a course of masterly inactivity regarding it, and the more so in that he felt that this accorded well with the views of the parents. But in such a case as this it is clearly the duty of the medical man to direct, not to acquiesce.

"After a prolonged and disappointing course of the old-fashioned and worthless treatment by iodine, the gland begins to break down in the centre and to grow soft. Then too often the second part of the routine treatment is entered upon, the long series of poulticings. In due course the skin of the neck grows irritable and eczematous, and as the glandular softening continues it becomes dusky, sodden, and undermined. Still nothing surgical, properly so called, is undertaken; nature is allowed to follow her own course. I am not one of those surgeons who have never a good word to say for a poultice; but still I have not such faith in its therapeutic value as had Bacon, for instance, who affirmed of a poultice that it 'relaxeth the pores and maketh the tumour apt to exale.' But Bacon was only a philosopher, and philosophy does not greatly lend itself to practical surgery. There are many practitioners who have, as regards poultices, made no advance upon the Baconian method, and who apply them to the child's neck with a faith like that of the African resorting to his fetish. But can moisture and warmth applied to the surface of the neck have any influence upon the condition of glands which are enlarging beneath the sterno-mastoid? I think not. But without doubt it can and does render the skin sodden and unwholesome, and, therefore, less prompt at healing when at last the gland is dealt with in a business-like manner."

Had the medical attendant known what modern surgery can do for these enlarged or broken-down glands, he would have strongly urged their removal by operation long ere that, and he could have given confident assurance that he, working from the outside and choosing his time, could produce a far better result than nature, working as she does from the dark interior, and fettered as she is by antiquated notions, which were her guide not only before the days of Lister, but even before the Deluge. Mr. Owen said that he spoke with all respect of "natural surgery"; but we should no more leave these cases of enlarged glands to the unaided treatment of nature than we should a carious tooth or a suppurating joint.

Supposing that no cause for the enlargement can be discovered, not even a nasal catarrh, the child must be treated on general principles, and, if convenient, sent for a change of air. If it be admitted that miasmata be the not infrequent cause of the enlargement, it is at once seen why a change of residence should be so beneficial. And supposing that the child has a history of strumous or tubercular descent, sunshine, warmth, fresh air, and sea breezes are most desirable for him, and especially as our cold, foggy, and damp winter is approaching. It were a new life to the child, then, to place him in a clime where the myrtles can flourish in the open air throughout the year, and where gentle breezes from a southern sea bring him almost day by day an increasing store of health and vigour. Though Broadstairs and Ramsgate may not be exactly such places as he was figuring, in that they are during the coldest months at times somewhat too keen and bracing, still they are rare havens for delicate children to winter in. "But of all places that I know in England, commend me to Bournemouth. I have seen no other winter quarters so delightful, and if I were told that Alma Tadema resorted thither every Christmas to paint his beauteous skies and seas, his lights and shades, and his oleanders, I should not be greatly surprised."

After extensive operations in necks of wretched children whose glands are involved in an advanced and widely spread decay, a vigorous clearance and erasion acts like the pouring of oil on stormy waters. But this much he can almost safely promise—that his operation, which will be associated with no great risk, may be trusted to effect a very great improvement, and that if it unfortunately has to be repeated, it will probably have prepared the way for a final and completely successful attack. The parents ought also to be made to regard the operation as not in any way of doubtful expediency or of a speculative nature, but as one that is the outcome of surgery, which is not only advanced but sound, not only scientific but practical and approved. Then there is the alternative, which should have due weight when the operation is being urged; if nothing be done, the case must take its own tedious, unsatisfactory, and even perilous course.

CONGENITAL CYSTIC HYGROMA.

After some preliminary remarks upon the nature of this variety of growth, the lecturer said that the surgeon must always be prepared for a hygromatous tumour becoming suddenly increased in size, hot, and tender; indeed, he will gladly welcome the attack of inflammation, provided that it does not assume extreme proportions, for he may with confidence expect that, on its subsidence, the tumour will steadily decrease, and in due course become effaced. Why the inflammation should so generally cause the subsidence of the tumour one cannot say. Neither, on the other hand, can one explain how it is that the attack of inflammation which he excites in the dropsical tunica vaginalis by the introduction of some irritating material usually cures a scrotal hydrocele. The analogy is sound, for the scrotal hydrocele is a dropsical effusion into a large lymph space—the tunica vaginalis; whilst the hygroma is a collection in small lymph spaces. "My belief is that it is only a matter of time when the critical inflammation attacks the hygromatous mass, for though I have seen dozens of these cases of dilated lymph spaces in infants and children, I have never (if my memory serves me) met with one after puberty. Certainly if the tumour be not greatly interfered with it very rarely entails death. It is by no means essential that obliteration of the cystic mass be preceded by inflammation, for the serum may undergo a quiet absorption, just as does the fluid which is so frequently found in the funicular process of the peritoneum or in the tunica vaginalis in little children. These hydroceles rarely need any treatment more serious than tapping, and that, I think, is all that should ever be undertaken in the case of the cystic hygromata."

That the hygromata are composed of dilated lymph spaces there is no doubt. These vary in size from cysts just visible to the naked eye to others of the size of a hen's egg or of an orange. They are lined with a layer of endothelial cells continuous with those of the lymphatics. As a rule, the hygroma consists of a great number of small cysts rather than of a few large ones, and it is the latter arrangement which gives rise to the so-called "hydrocele of the neck." On their being evacuated, however, the swelling does not entirely disappear, for, as a rule, puncture of the largest of the cysts causes others to assert their prominence, and when several of them have been emptied of their yellowish or blood-stained fluid, there is much growth left with which the operator is unable to deal.

The lecturer then passed round the photograph of an infant of eighteen months, whom he had recently seen with Dr. Fredk. Evans of Cardiff. The hygroma, which had been noticed directly after birth, had begun to grow six months later. It will be noticed that the growth extends across the median line of the front of the neck, but that, occupying the entire side of the neck, it reaches upwards behind the pinna. Close examination of the upper part showed that it even invaded the lobule of the ear. This is a very important clinical feature of the hygromata; every cervical hygroma does not involve the lobule of the ear, but there is no other form of cervical growth which trespasses upon the pinna without causing a discolouration of the surface, as a nævus would do, or without giving local and general signs of malignancy, as would a sarcoma.

Though hygromata are usually found in the neighbourhood of the neck, face, and armpit, still they may occur upon the trunk. Very rarely, however, are they found upon the extremities; still the surgeon must be prepared for encountering them there. Thus in November, 1882, the lecturer showed a child before a meeting of this Society with the remains of a hygroma upon the arm; the tumour had been for three years under his observation. At first its cystic nature had been very evident, but he had been content to watch it without offering to interfere; and when he brought the child forward the tumour had dwindled down into a diffuse mass, which greatly resembled a lipoma, the fluid part of the tumour having undergone spontaneous absorption.

It may be that in due course experimental physiology will not only be able to explain the occurrence of hygromatous tumours, but also supply a simple method for their prompt and successful treatment. In the meanwhile, however, the practical surgeon must be content to wait; and, in doing so he may, if he will, ponder over the Italian proverb which says that with patience and straw even medlars get ripe—*colla pazienza e colla paglia si maturano le nespole;* and though the proverb is of far wider application in surgery than some of us would believe, it is remarkably applicable in the treatment of congenital cystic hygromata.

Remarks
ON THE
CLINICAL ASPECTS OF MOVABLE KIDNEY.

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THAT movable kidney is of much greater clinical importance than the attention the subject had received at the hands of the profession would seem to indicate, is a proposition the truth of which I hope to establish in the following remarks. It appears to be a deeply rooted and widespread impression that an example of movable kidney is a clinical rarity, and that, when discovered, it cannot be made responsible for the symptoms of the subject of the anomaly; whereas, as a matter of fact, the condition is exceedingly common, whether viewed from the bedside or the post-mortem-room standpoint; and, further, is often, I believe, the cause of great inconvenience. Much of the doubt and diversity of opinion that exists upon this topic is traceable to the fact that clinical teachers have omitted to point out the renal displacement to the members of their class, who, in becoming practitioners without any acquaintance with the subject, are slow to accept as trustworthy anything that has escaped the attention of their own probably much-esteemed teachers. Others, again, whilst admitting that the condition is a common one, scarcely feel themselves free to subscribe to the opinion that it is the frequent cause of symptoms worthy of attention, which, I need scarcely point out, is the question that deserves consideration and requires to be ventilated. During the past few years a number of cases have occurred in my practice in which it could readily be demonstrated that one or both kidneys had by some means acquired more or less freedom of movement. In the majority of these cases certain symptoms were grouped together in such a way as to suggest pointedly a close connexion with the kidney mobility. I do not of course claim that we have here to deal with "floating kidney," employing the term to denote the condition where there is a true meso-nephron, which I believe to be a very rare anatomical anomaly; but I do claim that the displacement is a striking one, and in the majority of cases can easily be discovered if sought for in the proper manner. To this I shall return. I have endeavoured in the following series of clinical records to set out the salient points of the cases alluded to in as brief a manner as possible.

CASE 1.—Mrs. A——, aged fifty-four, mother of three children, consulted me for a pain of a burning and aching character in the lower part of the epigastrium, extending to the back, in the neighbourhood of the right kidney. Occasionally this pain was very noticeable in the right hypochondrium, whence it would pass to the shoulder-blade. In addition, she suffered from dyspepsia and palpitation. These symptoms had been more or less present for some years, but were on the increase, owing, she thought, to anxiety respecting the health of a member of her family, who required constant nursing at her hands. A physical examination revealed the fact that the right kidney was freely movable, and could be felt at the end of inspiration in the neighbourhood of the crest of the ilium. The left kidney appeared to be in its proper place. Exertion, such as lifting heavy weights or walking any distance, always increased the pain; whilst rest in the recumbent posture correspondingly relieved it. It was particularly striking that the degree to which she suffered depended largely on her general health. From time to time she experienced attacks of gastro-enteric catarrh, which quite incapacitated her, adding considerably to her more constant trouble. These illnesses (intestinal catarrh) usually began with a feeling of chilliness, and frequently, she believed, arose from unusual exertion, as in walking. Then the mouth became sore, and aphthous patches made their appearance on its mucous surface. The appetite next suffered, and slight fever at night occurred. And now pains more or less diffused over the abdomen were complained of, with special soreness above and to the right of the umbilicus. The bowels, which were usually constipated, became still more so; and after the lapse of a week or ten days from the onset mucus was noticed in the stools. This varied much in quantity, and from time to time long thin pieces resembling tapeworm, obviously casts of the intestine, were passed, or, again, a quantity of shreds of mucus could be seen. These catarrhal attacks compelled her to remain in bed, and usually lasted some weeks. In this case, it will be seen, there were two distinct forms of pain, one apparently directly due to the dragging of the displaced organ, whilst the other was naturally ascribed to a form of indigestion arising from gastro-intestinal catarrh. This latter condition is of such frequent occurrence in displaced kidney that I wish here to emphasise the fact. It was observed occasionally that, after exertion, for example, the effort made in climbing the Rothbury hills the kidney became enlarged and tender, whilst the urine was high-coloured and scanty, but without albumen.

CASE 2.—During an attendance upon Mrs. C——, aged thirty-seven, mother of four children, for an unusually severe attack of asthma with bronchitis, I had my attention called, as her pulmonary complaint subsided, to a dragging sensation in the outer part of the right lumbar region, extending into the hypochondrium. This, she stated, inconvenienced her very much from time to time, and had scarcely been absent for some years; it was always worse on standing and walking, and after an attack of asthma. On examination, the right kidney was discovered to be freely movable; the left was apparently in the normal position. Constipation and other dyspeptic symptoms were also noticeable features of the case, although no mucus had been observed in the stools.

CASE 3.—Mrs. S——, a widow, aged forty-nine, mother of two children, had for a long time been subject to indigestion, and was often troubled with a dragging sensation or pain beneath the right breast, extending into the hypo-

chondrium and lumbar region. These symptoms were aggravated on her falling into ill-health owing to mental anxiety and worry. Some years before she came under my notice she experienced the peculiar sensation of something moving about in the right side of her abdomen. After the death of her husband, when she was obliged to work for her living, the attacks of dyspepsia and the pain referred to became more frequent and severe. It was noticeable that the pain was worse on moving about and on exerting herself. The dyspeptic symptoms were usually at their height about two or three hours after food. The bowels were commonly constipated, and for some years she detected mucus from time to time in the fæcal evacuations, occasionally with some blood. Both kidneys were movable, but particularly the right, which could be dragged down as low as the crest of the ilium. Deep pressure was borne badly, probably on account of the tender condition of the ascending colon; for when the kidney was isolated it could be squeezed without producing pain, or the sickening sensation which has been referred to by writers on floating kidney as something almost pathognomonic.

CASE 4.—Mrs. M——, aged fifty-seven, three premature confinements, no children living, was seen for attacks of migraine, which had practically invalided her for years. She also complained of pricking, dragging, burning pains, which occupied the right lumbar and hypochondriac regions, and frequently ran down to the pelvis on the right side. She had suffered more or less from this pain for fifteen years. Exercise was sure to induce it, and anything that interfered with her general health invariably aggravated her suffering. The right kidney was very movable, and the left also could be palpated. Pressure over the right kidney produced an unpleasant sensation amounting almost to nausea.

CASE 5.—Miss R——, aged twenty-three, a tall, stout person, weighing 11 st. 4 lb., complained for two or three years of pains in the right hypochondrium, especially after walking, dancing, or playing tennis. They were of a dragging character, went through to the back and down into the pelvic region, and were generally worse at the menstrual periods. Occasionally these pains were noticed on the left side as well as on the right. Both kidneys were very movable, especially the right, which, although she was very stout, could be easily palpated. There were no peculiar sensations complained of on pressure, and no particular dyspeptic symptoms. It was interesting to note that exercise, when at all violent, produced slight albuminuria.

CASE 6.—J. B——, a fireman on an engine, aged twenty-four, had been much troubled for the past twelve months with pain in the abdomen, which he ascribed to inflammation. He was seldom without pain in either lumbar region, which was worse when going about. It was of an aching character, and extended up to the shoulders. After a long day on duty he suffered from a "weary and weak" feeling all over the lower part of the abdomen. The bowels were constipated, and frequent attacks of colic with diarrhœa occurred, during which mucus was noticed in the stools. Both kidneys were movable, the right one particularly so.

CASE 7.—Miss F——, aged forty, a lady of highly nervous temperament, complained of a dragging, prickling pain in the right hypochondrium, extending into the lumbar region and down to the cæcum. Relief was almost invariably afforded on lying down; exertion was prone to make it worse. She had suffered in this way for many years, though during the past three it had been aggravated. She ascribed her symptoms to a severe attack of dyspepsia attended by violent vomiting, which occurred several years before she came under observation. The right kidney was movable and tender, but the left was in its place.

CASE 8.—Mrs. M——, a young, newly-married lady, suffered from pain in the right lumbar region, which for the last four months had been almost constant, though aggravated at the menstrual periods and when she exerted herself. At first the sensation was more akin to numbness with prickling, but recently it had become genuinely painful. It affected the small of the back and at times would shoot round to the right hypochondrium and up into the shoulder. She consulted a uterine specialist, who told her there was contraction of the neck of the womb, on which her symptoms depended, and that an operation would be necessary. The right kidney could be felt very distinctly, and was tender on pressure. The uterus appeared to be in its normal position, and the cervix was elongated. As in nearly all the cases referred to, the severity of the symptoms bore a distinct relation to the patient's health. When in Scotland, some weeks after the above note was taken, she caught cold, and when again seen she was confined to bed with the right pleura full of fluid. Now, strange to say, although the kidney was still further pushed out of its place by the weight of the effusion, the old dragging pain was scarcely complained of at all.

CASE 9.—Mrs. S——, a highly nervous woman, aged thirty-seven, mother of three children, complained of pain of an aching character in the left side for upwards of ten years. This first occurred when pregnant with her first child (about four months). After the confinement, which was very severe, and during which she was much lacerated, she had a great deal of aching pain on both sides, and was much troubled with attacks of indigestion and diarrhœa. Her pain was chiefly situated in the left hypochondrium and lumbar region, though it frequently extended over to the right side. Both kidneys, especially the right, were movable; the latter could readily be brought down to the crest of the ilium. Her pain was generally worse when menstruating—at the beginning of the period. There was no pain on pressing the kidney. She suffered from migraine.

CASE 10.—Mrs. W——, aged thirty-one, mother of three children, for five weeks complained of pains in the right lumbar region, extending to the spine and towards the pubes. She described it as an aching pain, and stated that it was sometimes felt in the left side, when it usually passed down to the hip. She did not know what induced it, but thought it was probably the result of exertion in using a heavy wringing machine. It was very significant, however, that on the same day as that on which she first felt the pain her husband was brought home injured in a pit accident. She had suffered from hysterical fits for years, and also from migraine. Both kidneys were very movable, especially the right, which could not be replaced in its proper position, and appeared to lie immediately below the anterior abdominal wall, just above the brim of the pelvis. The aorta was prominent and pulsated strongly.

CASE 11.—Mrs. ——, aged forty, mother of a large family, suffered for eighteen months from mental distress, the result of the discovery that her right kidney was floating, a fact told her by her medical attendant, whose attention she called to a tumour in her side. She was a thin, spare woman, and her kidney could be palpated very freely. It could be placed, for example, on the front of the spine and dragged on to the crest of the ilium, though it vanished under the ribs when she lay down and at the end of expiration. The left kidney could also be felt, though it was evidently anchored more closely than the right. With the exception of the mental distress arising out of the knowledge of the deformity, she was practically in good health, though occasionally an aching pain was complained of under the right shoulder-blade and extending into the right hypochondrium.

CASE 12.—Mrs. H——, aged thirty-two, a thin, pale, delicate-looking woman, without any family, suffered more or less for eleven years from dyspepsia and pain across the upper part of the abdomen. She ascribed her indisposition to a severe attack of vomiting, which was practically her first acquaintance with dyspeptic symptoms. This lasted for several days, and after it subsided she detected a "lump" which she could handle freely in the right hypochondrium. She consulted a physician, who sent her to a surgeon to have the tumour removed. The operation was arranged for, but fortunately was not carried out owing to the sudden disappearance of the tumour when the patient was on the operating table, just as the surgeon was about to commence. Some months before she came under my notice gastric symptoms and vomiting returned, and these were followed by a constant aching in the small of the back and right hypochondrium, aggravated on standing or walking, though it almost invariably passed off when lying down. The right kidney was very movable, and the left was in the same condition, though to a less extent. Pressure on the right kidney caused a disagreeable sensation of nausea.

CASE 13.—E. M——, aged thirty, the mother of five children, complained from time to time, for upwards of seven years, of pain across the middle of the abdomen, lower part of the back, and right hypochondrium. She was seldom without pain in one or other of these positions. Exertion increased her suffering, and rest materially lessened it. After a confinement, about five years before she came under observation, she discovered a "lump" in

both hypochondriac regions, the right being noticed first, and that in the left soon after. She was nervous and depressed. Both kidneys were markedly displaced.

CASE 14.—T. A——, a joiner, aged thirty-eight; treated for anomalous pains in the abdomen. He suffered for years from aching pains in the lumbar region and lower part of the abdomen, chiefly on the right side; but was able to follow his employment until nine months before his admission into hospital. He recently lost flesh, and was—at the time the notes were taken—1½ st. below his average weight. He suffered much from dyspepsia, which was revealed chiefly by pain in the epigastrium, loss of appetite, vomiting, flatulence, and constipation, with frontal headache and marked mental depression. The epigastric pain was induced by food, and was usually at a maximum an hour or two after meals. Mucus was frequently observed in the stools. Both kidneys were freely movable, more particularly the right, which was sometimes found as low as the brim of the pelvis. Nephrorraphy was performed by Mr. Dodd.

CASE 15.—M. C——, a sick nurse, aged thirty, unmarried, came under observation for dyspepsia with abdominal pain and general debility, which sometimes obliged her to desist from her employment. She dated her symptoms from a severe attack, supposed to be peritonitis, which occurred ten years previously, and which was attended with abdominal pain and severe vomiting. The pain and dyspepsia returned from time to time whenever her state of health was below par, occasionally obliging her to rest for several weeks at a time. About seven weeks before she came under notice she was again laid up, and now suffered from diarrhœa and pain in the right lumbar region, extending into the hypochondrium towards the umbilicus, and passing at times over to the left side of the abdomen. These symptoms were worse at night, and were aggravated by exertion. Mucus was noticed from time to time in the stools. The right kidney could be felt below the ribs, but appeared to be free from tenderness on manipulation.

CASE 16.—Mary N——, aged thirty-one; married; no children. Her illness dated from an attack of vomiting with dyspepsia, which seized her about eight months before she was admitted into the Royal Infirmary under the care of Dr. Hume. The vomiting continued daily for about a fortnight, during which time she was often troubled with retching. A little later another similar attack took place, with severe straining and retching, which confined her to bed for a few days. When this subsided she discovered a "swelling" in the situation in which she had complained of pain—namely, the front of the right lumbar region, an inch or two below the arch of the ribs. This swelling disappeared on lying down, to return whenever she sat or stood. From this date she was very much troubled with aching pain in the neighbourhood of the swelling and extending into the back. The discovery of the tumour induced mental depression, and made her excessively nervous. She was generally constipated, though at times the bowels were unusually loose, and mucus was often noticed in the evacuations. The right kidney was freely movable, and could be felt from time to time on the level of the anterior superior spine of the crest of the ilium. It usually occupied a position about half an inch above the level of the umbilicus, but frequently disappeared into its normal position. No particular tenderness on pressing the kidney was complained of. Nephrorraphy was performed by Dr. Hume (right kidney) on Dec. 20th, 1888. When seen on April 30th, 1889, she was much stouter, and she stated that she was practically quite well.[1]

CASE 17.—Mrs. M——, aged sixty-four, mother of several children, complained for several years of an uneasy sensation in the region of the stomach after food, especially when fatigued. It was generally worse after dinner. She suffered from constipation and sick headache. She stated that she was thinner than usual. Both kidneys could be palpated, especially the right.

CASE 18.—Mrs. A——, aged sixty-six, a stout but feeble-looking woman, no children, was seen for shortness of breath on exertion, cough, and general debility. Floating right kidney was discovered, although no symptoms suggestive of such a condition were complained of by the patient.

CASE 19.—Mr. A——, aged twenty-three, was seen for a dragging, uneasy sensation in the right lumbar region, chiefly in the front, which had troubled him very much for years, and was most noticeable when he exerted himself. Here the right kidney was found to be loose in its attachments, but the displacement was not by any means striking.

CASE 20.—Miss T——, aged fourteen, a pale, delicate-looking girl, was troubled with aching pains which passed round the right side of the abdomen from the floating ribs towards the umbilicus. These had been noticed for some weeks, but had quite recently become aggravated. She often suffered from diarrhœa, though from time to time the bowels were constipated. No mucus was noticed in the stools. The pain was decidedly worse on moving about, and she always got relief when she lay down. The right kidney could be grasped with ease and moved into various positions in the neighbourhood of its normal situation.

(To be concluded.)

[1] I have since ascertained that this patient has relapsed into her old state.

OBSERVATIONS ON ABSCESS AND OTHER DISEASES OF THE LIVER.

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THE following paper was mainly written, but not published, many years ago; some of it at a time when soldiers invalided home from tropical or subtropical climates, who were found on arrival too ill to proceed to Netley, had to be disembarked at Portsmouth and admitted to the garrison hospital there. Such additions have been made as have been derived from subsequent experience on the Army Medical and Indian Medical Boards respectively and in India and elsewhere; but no reference has been made to the various and valuable books which have appeared on the subject. I have simply attempted to describe the impressions derived from my own personal experience and observation.

Imprimis, there are a few anatomical considerations which are not without practical interest, and deserve to be borne in mind. The liver is by far the largest gland, and its vena portæ and vascular system are sufficiently capacious to contain pretty nearly all the blood in the body. It measures from ten to twelve inches in its transverse, and from six to seven inches in its antero-posterior diameter, and it is about three inches thick at the thickest part of the right lobe at the back. At its right extremity it is large and rounded; thin and flat at its left; and its position is such that a needle inserted directly backwards from the middle line in front would easily pass quite through its substance. The position occupied by the liver and the limits within which this varies according to the posture of the body and the action of the diaphragm, as well as the way in which these limits may become altered by conditions affecting the capacity of the thorax; the relation of its more bulky part (and its convex vaulted shape) to the under surface of the diaphragm on the one hand, and to the large vessels, stomach, and intestines on the other, are anatomical considerations which obviously have a very direct bearing on diagnosis, on the frequent site of an abscess and the course it may take, as well as a very practical one on surgical treatment—for instance, as to how the abscess can be best reached with least risk of injury, and the relation of a drainage-tube to the cavity of a liver-abscess after it has been reached.

Suppuration of the liver may arise under one or other of the following conditions: First, what may be called metastatic abscess, in connexion with an ulceration, sloughing or allied morbid process in the intestines, and most commonly of the large intestine, the result of dysentery, where from the introduction of septic or other vitiated materials into the tributaries of the portal vein—as pointed out years ago by Dr. Wm. Budd—embolic abscesses ensue. Secondly, as one of the pathological products of that general contamination of the blood known as pyæmia or its congeners, where the presence of pus in the liver is associated with abscesses of other parts, such as the lungs, joints &c. This is comparatively rare. Thirdly and lastly, but from a curative point of view the most important, where there is an affection of the liver of which

abscess is the result, irrespective of and unconnected with dysentery or other diseased action in other parts of the body.

Although dysentery and liver disease (including abscess) generally march together, it must be conceded that hepatic abscess often takes place from the operation of causes which lead primarily to a congestion of the liver *per se*—venous and biliary congestion—irrespective of dysentery. On the one hand, cases of hepatic abscess occur in tropical countries—in India, Ceylon, and elsewhere—without any dysenteric disease; and on the other, dysentery often runs its course without any hepatic mischief; and even when the two coexist—dysentery and hepatic abscess—their relation to one another is not invariably and necessarily, although it is commonly no doubt, one of cause and effect; the size, solitary nature, and peripheral thickening of the liver abscess sometimes indicating an origin antecedent and not subsequent to that of the dysentery.

Of the frequent association and causal connexion of dysentery and hepatic abscess, however, there can be no doubt whatever. The evidence of it has been accumulating from the days of Dr. William Budd to the present time. Indeed, cases of hepatic abscess met with in this country usually possess a history of dysentery, or some of the anatomical signs of that disease are found after death. I am indebted to my friend Dr. John Anderson, C.I.E., Physician to the Seamen's Hospital (late *Dreadnought*), for the following information. From the post-mortem records of that institution it would appear that, out of sixteen fatal cases since 1880, twelve occurred in connexion with dysentery and five without. Of the former no less than seven were instances of single abscess, and five multiple. In addition to the above there was one case that could not be classified as regards dysentery. My experience abroad, however, would lead me to infer that cases of abscess of the liver, independent of and unconnected with dysentery, were not at all uncommon; and when such is the case we can generally discover some anatomical characters which distinguish this form of hepatic abscess from the metastatic variety. The former are commonly large and solitary, containing a considerable quantity of purulent fluid, with cells like true pus cells, and the abscess is shut off from the liver substance by a more or less tough fibrous enveloping wall. The metastatic variety, on the other hand, consists commonly, but not invariably, of multiple abscesses of very different dimensions, from the size of a pea, walnut, or hen's egg, to that of a large abscess, containing the detritus of broken-down and necrosed liver tissue mixed with a puriform fluid rather than true pus, and more rarely confined by any limiting membrane: the walls of the abscess consisting rather of the softened spongy or necrosed substance of the liver itself.

My observations are corroborative of those of Dr. F. N. Macnamara on the morbid changes which apparently precede the formation of pus. The liver presents certain drab-coloured patches which contrast with the somewhat engorged aspect of the gland generally, and retain their colour after the liver has been incised and the blood has escaped. There is a peculiar granular degeneration of the liver cells in the drab-coloured patches, which soften in their centres and become puriform in appearance, with ragged, spongy-looking parietes.

A liver abscess may burst into the intestine, lungs, or other contiguous parts; or it may be opened naturally or artificially, of course, through the integuments, the pus sometimes taking less common channels or making curious tracts and sinuses, the causes of which generally admit of anatomical explanation. The patient suffers, perhaps, at first from symptoms of inflammatory enlargement of the liver, with or without fever and subsequently rigors and hectic, the latter being probably the effect of pent-up pus, and of a sort of chronic subacute pyæmia—the chronicity of the symptoms and the less rapid fatality of the disease being due to the fact that the amount of blood poisoning induced is never far in advance of the eliminative action it sets up. The metastatic form is the more dangerous to life; it more rarely terminates by rupture and discharge of the abscess and the return of good health.

These descriptions are necessarily drawn more sharply and defined in outline than we must expect to meet with them in practice; for we cannot always determine during the lifetime of the patient to which variety the hepatic disease belongs. Still, the distinction is not without practical advantage in connexion with the question of the advisability of opening an abscess of the liver or of exploring that organ in cases where its existence is suspected. The cure of an abscess by operation is more likely to occur in the case of an idiopathic large solitary abscess. In those of dysenteric origin, it occasionally happens, however, that an embolus in the liver gives rise to a single abscess, or several abscesses unite together and form one. Where there are numerous abscesses it is scarcely necessary to add that little benefit can be anticipated from opening one of them; indeed, there is a risk of contributing something to the danger of the case by the infliction of a surgical injury. In a patient who had been suffering from the symptoms of hepatic abscess, there appeared a fluctuating tumour projecting from the liver beneath the ribs. It was very properly suggested that the right course was to open this and evacuate its contents. It would certainly have been easy to have done this, as was proved shortly afterwards on the dead body of the patient in the post-mortem room; but, on further examination, the abscess was found to be one of many in the substance of the liver. An opinion adverse to the operation in the patient's lifetime was arrived at mainly from the fact of his having suffered from severe dysentery, which favoured the view that the liver was the seat, not of one, but of many, metastatic abscesses; and this proved to be the case. Unfortunately, the symptoms of hepatic abscess are frequently so slight and so little urgent that there may be no suspicion of its existence on the part of the patient himself or his attendant. Everybody who has any experience of this disease knows this. There may be a complete absence of all subjective symptoms, or only a feeling of illness, with or without some dyspeptic symptoms; and the subject of hepatic abscess may have returned from the tropics, resided for some time at home, and followed his usual occupation, and yet eventually die of that disease, his health having apparently been good in the interval.

It is obvious that, as regards surgical treatment, a great deal turns on the early diagnosis, for the longer the abscess has lasted the greater is the destruction of the tissue involved and the greater the risk of symptoms from pent-up pus, or of grave constitutional disease, or of some untoward accident. It goes without saying, that the possibility of liver abscess should always be suspected in the case of persons who have resided abroad in hot or malarious countries. There is no symptom, or group of symptoms, by which the diagnosis can be established with absolute certainty short of the discovery of pus. In the case of an officer in India to whom I was called in consultation there appeared, in addition to symptoms pointing to liver disease of some kind, a distinct prominence of the abdominal parietes over the site of the right lobe of an enlarged and tender liver. An abscess was diagnosed, and it was proposed to evacuate it then and there. Something occurred to cause us to postpone the operation. The swelling, whatever its exact nature, together with his other symptoms, soon disappeared. The officer went home and remained there for many months, during which his health became sufficiently re-established to warrant his return to India, which he did, and subsequently died there of some disease the exact nature of which I did not learn. Unfortunately there was no post-mortem examination, and it is possible that he had liver abscess after all.

In any case where the symptoms are of a more or less anomalous character, but not inconsistent with the assumption that they are due to this cause, we can commonly reach a correct conclusion by attention to the following:—1. Careful examination of the liver, from time to time, to ascertain its size and the presence or not of any tenderness. 2. The systematic use of the clinical thermometer, for the detection of any febrile changes. 3. Examination of the chest—especially of the right chest,—to detect any signs of disease in the lung or pleura. 4. A consideration and comparison of the results of such examination with those of the patient's medical history, past and present, as regards his complexion and facial expression, the presence of diarrhœa or dyspeptic symptoms, rigors, hectic, inability to lie upon the left side, emaciation, and depression of spirits. It cannot be too strongly urged that, in any case, the best way is always strongly to suspect abscess.

En passant, I may remark that jaundice is frequently absent in cases of liver abscess, and it is somewhat remarkable what an amount of liver substance may be destroyed without the appearance of any jaundice. Anasarca may

result from pressure on the vena cava, as I witnessed in a case which Dr. J. Anderson was good enough to show me.

An investigation into the causes of liver abscess is attended with some difficulty. As everybody knows, it is a disease of hot countries; still, it is not the heat *per se*, for, while hepatic disease is common enough in the East Indies, it is comparatively rare in the West India Islands, notwithstanding that dysentery occurs there. This fact did not escape the attention of old observers, who pointed it out as a remarkable thing that in the East Indies, at Madras, and Bombay, under nearly the same latitude as Jamaica, hepatic disease was so much more prevalent among the European population than at the later station. During the five years 1883–7 the amount of dysentery among the troops in the West Indies equalled an average ratio of 9 per 1000, considerably lower certainly than the Indian average ratio for the same period. Inflammatory affections of the liver, including abscess, were, however, altogether more frequent in the East Indian stations. Again, liver abscess is not equally common in the three Presidencies, and considerable differences exist in this respect between different districts of the same Presidency; but the admissions for liver diseases for the eastern district of Madras and Burmah, the Allahabad and Presidency districts of Bengal, and the Presidency and Poonah districts of Bombay always keep high. Hepatic abscess is common enough, too, in Ceylon and China. Speaking generally, it is rather a disease of hot moist climates than of hot dry ones, and of places on or near the seaboard than of others more inland. Considerable diurnal variations of temperature leading to chill predispose to its occurrence, but there is something more than this; neither can it be said that the presence of malaria or dysentery and the liability to hepatic abscess are quite conterminous expressions. Children have large, voluminous livers, and are liable to attacks of dysentery, but liver abscess is rare among children resident in India. During the five years ending 1887 there were only eight cases returned as hepatitis (including abscess) among the children of the British Army in all India. Women suffer more than children, but less frequently than men, from abscess of the liver.

It is an old notion, but physiologically a true one nevertheless, that in hot climates the hepatic function is exalted because that of the lungs is lowered. My own observations would lead me to think that, as regards climate, heat and moisture; as regards personal causes or conditions, an excess of, as well as an improper, diet, consisting of too much meat and alcohol; and as regards the exciting or determining cause, chill, causing engorgement of the abdominal viscera—form the main factors making up the pathological *rôle* of acute hepatic disease. In a hot, dry temperature, where the products of perspiration are rapidly carried off, there is less tendency to passive and continued visceral engorgement than in conditions of the atmosphere where these are less freely carried off, and the individual lives in a kind of steam bath, the functions of the skin fluctuating, however, with even slight changes of temperature.

If it cannot be said that we can guarantee Europeans going to a tropical climate an absolute immunity from liver abscess by the exercise of any amount of personal care, I have no doubt that a high degree of immunity can be secured by a little attention to personal hygiene—to wit, by adjusting the diet in quantity and character to the nature of the climate, by guarding against chill, and by attention to the maintenance of a regular state of the bowels. It is astonishing how short a residence in the tropics may sometimes be productive of hepatic abscess. For instance, many years ago a medical officer went from England to India just at the end of the hot weather, and returned to this country, after about six weeks in India, in apparently good health. He remained at home, and believed himself to be, as he appeared, in excellent health; but he died quite suddenly of peritonitis and collapse, caused by the bursting of a liver abscess into the peritoneal cavity.

In past times, when longer service in the British Army was the rule, and less care of the health of the soldier was exercised than is now done, there were unfortunately frequent opportunities for tracing among the invalid soldiers landed at Portsmouth from India, China, and elsewhere the inimical effect of a tropical climate on the constitution. Invalid soldiers had an anæmic and asthenic aspect, and they possessed relatively little rallying power. But what told the tale most plainly was the premature appearance of age.

(To be concluded.)

ON SOME AFFECTIONS OF THE BURSA PHARYNGEA.[1]

BY ADOLF BRONNER, M.D.,
SURGEON TO THE BRADFORD EYE AND EAR HOSPITAL.

THE affections of the pharyngeal tonsil play a very important part in connexion with the treatment of the diseases of the nose, ear, and throat. It was Meyer of Copenhagen who first drew attention to the frequent occurrence and great importance of what he called "adenoid vegetations of the naso-pharynx, or post-nasal growths."[2] These growths are, as Trautmann[3] and others have proved, simply a form of chronic hypertrophy of the pharyngeal tonsil or adenoid tissue situated at the vault of the naso-pharynx. Meyer also recognised the important relation between post-nasal growths and diseases of the middle ear. Of 198 cases of diseases of the middle ear in children under fifteen years old which I saw in 1887 and 1888, post-nasal growths were found in 101. Of 152 cases of post-nasal growths, the middle ear was affected in 125 cases, or over 85 per cent.[4] The growths are also of great importance in connexion with the development and diseases of the chest. Patients with well-marked growths have in most cases a narrow and undeveloped chest, and often suffer from bronchitis and affections of the lungs. There is another very common affection of the pharyngeal tonsil, "catarrh of the bursa pharyngea," to which Professor Tornwaldt first drew attention in 1885.[5] Tornwaldt shows that in many cases of so-called post-nasal catarrh, if we carefully examine the pharyngeal tonsil, we see near the middle line a greyish crust of dry mucus. On removing this, we find attached to its upper surface a plug of tough mucus which comes out of one or more small apertures in the middle line of the tonsil. On passing a probe through one of these apertures we find a large cavity which extends backwards and forwards, often to the extent of one or two centimetres. Often the middle of the tonsil bulges forwards, and on pressing it with a probe we can distinctly see mucus escaping from some small aperture. These latter cases have been described as "cyst of the pharyngeal tonsil."[6] Mucus, dry and similar in character, is often found on the posterior wall of the pharynx. Tornwaldt calls this cavity the "bursa pharyngea." He thinks that this bursa is a congenital structure, and developed in most persons, but readily recognised only when inflamed. Schwabach,[6] G. Killian,[7] and Suchannek[8] have lately proved that there is no such thing as a congenital bursa pharyngea, and that this so-called bursa is formed by pathological changes which take place in the fissure, which normally divides the pharyngeal tonsil from before backwards. The sides of this fissure become inflamed, and then often adhere together, thus forming, as it were, a covered passage which presents all the features of a bursa. Schwabach suggests calling the fissure the "recessus medius pharyngeus." Even if these assertions be true, the work of Tornwaldt does not, therefore, lose any of its great importance from a practical point of view, and deserves much more attention than has hitherto been given to it. The great importance of the catarrh of the bursa pharyngea is its intimate relation to the affections of the neighbouring parts—the pharynx, nares, Eustachian tube, and middle ear. The constant secretion of mucus from the diseased bursa sets up inflammation of the surrounding tissues, and this inflammation can spread to the nose or throat. Or the mucus, which is often of an offensive nature, drops into the nose or throat, and sets up inflammation there.

We thus find that many cases of pharyngitis in all its varieties are caused and kept up by the catarrh of the bursa. The complex of distressing symptoms, usually called relaxed throat, or post-nasal catarrh, so very common in the north of England, is in many cases caused by the mucus which

[1] A paper read before the Leeds and West Riding Medico-Chirurgical Society, November, 1889. [2] Hopitals Tidende, November, 1867.
[3] Anatomische, Pathologische und Klinische Studien über Hypertrophie der Rachentonsille.
[4] Post-nasal Growths and their relation to Diseases of the Middle Ear, Brit. Med. Jour., July 14th, 1888.
[5] Ueber die Bedeutung der Bursa Pharyngea für die Erkennung und Behandlung gewisser Nasenrachenraum Krankheiten.
[6] Archiv für Microscopische Anatomie, 32, pp. 187.
[7] Ueber die Bursa und Tonsilla Pharyngea, 89.
[8] Beiträge zur Pathologischen Anatomie und Allgemeiner Anatomie, iii., pp. 1.

is constantly dropping from the diseased bursa. These are the so-called incurable cases in which gargling, painting, and burning with the galvano-cautery are of no use whatever. Chronic hypertrophic rhinitis is often caused and kept up by the catarrh of the bursa. In these cases even the most barbarous treatment of the nares must naturally fail to effect a cure. I will record some typical cases of catarrh of the bursa pharyngea which have come under my notice.

CASE 1.—Miss K——, forty, saw me in February, 1888. For many years she has been troubled with an irritating, dry cough every morning. She feels as though there were a hair in the throat. After the coughing, she usually expectorates quantities of dry mucus, which is of an offensive nature. She often suffers from "cold in the nose and head." On examination I found the pharynx congested and several large granulations; the posterior wall was of a peculiar pale, shiny colour, and looked as if it were glazed over, and was partly covered by several crusts of yellow mucus; the lower turbinated bones and septum were swollen; the pharyngeal tonsil was enlarged, and partly covered by a crust of mucus. I removed the crust. A small slit was now visible near the middle of the tonsil. I introduced a probe, and found a cavity, which extended backwards and forwards for about one centimetre and a half. The bursa was touched freely with chromic acid several times. In three weeks the cavity had disappeared, as had also the cough and crusts of mucus in the pharynx. The nose has been perfectly free ever since.

CASE 2.—Miss M——, aged twenty-eight, governess, consulted me in May, 1888. For some months she had complained of severe pain in the forehead, worse in the mornings and of, as she thinks, loss of memory. She cannot work as well as formerly, feels tired and weary, and takes no interest in her duties. In fact, she feels so miserable that she intends giving up her situation as governess. She thinks that these symptoms are in some connexion with the eyes, and wants glasses. The vision and accommodation of the eyes were perfectly normal, so that I had to look for the origin of the symptoms elsewhere. I found that she nearly always had a "cold in the nose," and suffered from a dry cough in the morning. The lower turbinated bones were much swollen, and there was well-marked granular pharyngitis. The pharyngeal tonsil seemed enlarged. On careful examination I found in the middle of the tonsil a round elastic swelling of the size of a large pea. On piercing it with a pointed probe, a quantity of offensive mucus escaped. The patient felt much relief for several days, but the old symptoms soon returned. In July I removed the whole of the bursa with Trautmann's sharp spoon. In September the patient came again. She said that she felt her old self now, and was perfectly happy and contented. The cough, headache, and all other symptoms had completely disappeared. This is a typical case of "aprosexia," so ably described by Professor Güye,[9] and so very common in children who suffer from post-nasal growths.

CASE 3.—Mr. S——, aged thirty, saw me in June, 1888, for deafness. For five years he has had frequent attacks of deafness of the left ear. He noticed that these attacks were always accompanied by swelling of the left nostril and by a dry cough. On examination I found the left lower turbinated bone swollen. There was well-marked granular pharyngitis. Numerous scars on the posterior wall of the pharynx were the sole remains of a recent treatment with the galvano-cautery. Near the middle of the pharyngeal tonsil there was an accumulation of dry mucus. I removed this and found two small apertures, which opened into a fairly large cavity. By the use of the Eustachian catheter the hearing was restored. The bursa was cauterised with chromic acid seven times. I saw the patient again in November last. The deafness has not returned, and he has lost the cough altogether.

CASE 4.—Rev. J—— saw me in January, 1888. For many years he has suffered from an irritating dry cough, which was always the worst in the morning. After coughing he usually expectorated quantities of tough mucus. He also suffers from vomitus matutinus. For some months he has been subject to frequent attacks of slight hoarseness and weakness of voice. Several times his voice gave way in the middle of the sermon. He has tried all kinds of remedies: nasal douches, galvano-cautery, &c. He is also subject to attacks of slight deafness. I found the pharyngeal tonsil enlarged and covered with several crusts of mucus. These were removed, and two small slits were then visible, which opened into a cavity. I scraped the bursa with a curette, twice. In February the cough had quite gone, and since April the patient has never had cause to complain of hoarseness, weakness of voice, deafness, or vomitus matutinus.

As regards treatment, this can of course only be local. We can either cauterise the walls of the bursa with chromic acid, nitrate of silver, or with the galvano-cautery, or we can remove the whole of the bursa with a sharp spoon or curette. I formerly used Trautmann's sharp spoon or Kartman's curette, but found that they were too large, and obscured the field of operation. I have had a curette made by Down Bros. similar in shape to Kartman's, but much smaller. With it you can, under guidance of the post-nasal mirror, readily remove the bursa or cyst. The end *a* (natural

size) is passed through the mouth behind the soft palate, pressed well against the pharyngeal tonsil, and drawn from one side to the other several times. In nervous patients I should recommend the use of some caustic; chromic acid fused on to a platinum probe seems to me to be the best. In most cases, however, the surgical treatment is certainly the simplest, easiest, and quickest way of getting rid of the bursa. The pharynx and naso-pharynx should be painted with cocaine, 20 per cent. solution, several times, a few minutes before examination, and of course also before the operation. I also use the cocaine spray. In some cases we have to pull forward the soft palate in order to get a full view of the naso-pharynx. I prefer Voltolini's retractor to those suggested by Krause, Cresswell Baber, and others, which are fixed to the upper jaw. A small laryngeal mirror suffices in most cases, or one can use Fraenkel's or Mackenzie's movable mirror, or the large concave mirror as suggested by Professor Wahl.[10]

Bradford.

[9] Brit. Med. Jour., Sept. 28th, 1889.

[10] Erfahrungen auf dem Gebiete der Nasen- und Rachenkrankheiten, 1888.

ON INFLUENZA AND THE PRESENT EPIDEMIC.

BY WILLIAM SQUIRE, M.D., F.R.C.P.,
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THE old epidemics of influenza, one of which afforded my earliest objects of clinical study, were characterised by sneezing, coryza, and frequent cough; by a sudden onset with chills, aching pain in the eyes, head, neck, back and limbs; and by marked fever of no long duration, followed by great depression, a slow convalescence interrupted by relapses, by certain affections of the respiratory apparatus, or by various complications. The present epidemic has assumed these characteristics in many parts of Europe; but with us, as far as it has yet been investigated apart from the very various ailments confounded with it, the attacks are without many of the first-named symptoms, and we have yet to hear of the more serious after-effects of epidemic influenza. We have around us an epidemic of a specific kind, and, further, an epidemic dread of something worse to follow. Catarrhal attacks have been spoken of any time these forty years as "influenza colds" without exciting undue apprehension; for, though more frequent at one season of the year and much more in some years than others, this sporadic influenza was generally infectious to a limited extent, spreading in small circles only, and not acquiring the full power of a widely diffused infective epidemic such as was witnessed by many of us in 1847 and heard of in the years 1832 and 1837. The Annals of Influenza (Sydenham Society, 1852) give records of some twenty epidemics from the sixteenth century; the second of these reached America, that of 1782 was most noted here, and very generally under the name of "influenza." A chief feature

of all these outbreaks was their highly infective power. Cold does not prevent this infectious quality; it survived the Russian winter in the epidemic of 1781–82, as in subsequent epidemics. The last two epidemics in England prevailed during frost and snow; a recurrence of influenza attacks was observed in the cold winters of 1853 and 1860. Cold weather alone will not give rise to influenza catarrh; in the Hebrides and in Skye colds and coughs, absent in the winter, have been noticed to appear in the spring after the first ships call there on their northern way.

The present epidemic in London and many parts of England does not as yet show this highly infective power. A large number of persons similarly situated as to occupation and mode of living seem to have been seized at once, but not to have taken the infection one from another. In a family or household where one or two members have suffered the majority have escaped. Of the many convalescents moved from London to Brighton in the past month few, if any, have conveyed infection; and Brighton since Christmas, when at its fullest, is freer from the kind of illness called "influenza" than many places in less direct communication with London. On the other hand, a telegram from Monte Carlo of Dec. 22nd says: "All the doctors are busy here with influenza victims, though most of the patients brought it with them." Fortunately for us, the set of English travellers in the winter is towards and not from the centres of the European epidemic, so that the worst of our winter weather may be over before any new impulse is given to the existing epidemic.

In all records influenza is noted to appear under two forms, marked by the severity of nervous symptoms in one, and of the catarrhal in the other. The former includes the sudden chills and pains of the ingress, the aching and soreness of the febrile stage, and the subsequent neuralgias; while to the latter belong sneezing, violence of cough, and various pulmonary consequences. Either of these forms may become prominent in some epidemics or in parts of an epidemic, but no essential difference can be based on such a distinction. The sudden ingress with severe pain and fever observed in some recent cases of the illness, and those not always of the worst kind, has led to the naming this form of the attack "Russian influenza," and to viewing it as a disease altogether different from the catarrhal form. Before insisting on the identity of the two clinically and their mergence into each other, a few facts as to their coexistence in the present European outbreak may serve to show how little foundation there is for any such new name, and to suggest the possibility that the continental form of the epidemic has not yet gained a footing amongst us. First, we may note that on the first appearance of influenza in Russia it extended in no one direction only, and has since followed the chief lines of communication. At the end of November we hear of it in Germany and Austria; Vienna suffered in the first week of December; Paris and Berlin by Dec. 11th and 12th—possibly sooner. Brussels followed Paris about Dec. 14th; from Vienna it spread to Buda-Pesth by Dec. 14th, and thence eastward to Sofia. A simultaneous extension westward took place from France to Spain and Portugal, and southward somewhat later to the Riviera, Italy, and Malta. The prevalence of influenza to the north of the Baltic and in North America, not much in excess of what is usual at this time of year, is probably not an offshoot of this latest Russian outbreak. A claim of affinity was, however, made by telegram in the middle of December from Boston, U.S.A., and from New York. A similar claim is now made (Jan. 3rd) for an extension over the States to Mexico; and also from Toronto, Montreal, and Quebec. At this time of year, or with the first thaw, colds and influenza are general in Canada, and a telegram from Quebec reports "forty cases to be Russian influenza in a very mild form, with no serious cases, though spreading rapidly."

Apart from starting epidemics by telegraph, enough is before us to raise for our consideration the question of the simultaneous action over wide areas of causes predisposing to disease, together with the development or conveyance of the special germ necessarily concurrent in any distinctive epidemic disease. Influenza has been so long established in North America as well as here that no new germ need be imported by letter or parcel from France or Russia to explain its recurrence. The general causes predisposing to a rapid development of influenza, however imperfectly ascertained, are known to come into operation at long and uncertain intervals. That the special features of this epidemic are not of continental origin the isolated position of many of the places first attacked sufficiently shows. Many cases with sudden pain and fever occurred in the villages of Bolingbroke and Keal between Spilsby and Lincoln early in December, some of them at the same time as the Vienna extension, of which no news had then been received. Since then we hear of a similar outbreak at Langtoft in the Yorkshire Wolds; and also at Grange in Lancashire on our western coast. Again, the sudden pain and fever regarded as peculiar to the continental outbreak are by no means more marked than are the symptoms common to all epidemics of influenza. A medical report from Vienna of Dec. 13th gives the following clear account of these symptoms—viz.: (1) a definite incubation of two days only; (2) prodromal signs of prostration, headache, chills, of a few hours only; (3) fever of three days' duration, with either (*a*) nervous symptoms only, as severe pain in the head, back, and limbs, with other neuralgias; (*b*) with catarrh, sneezing, and bronchial catarrh; or (*c*) with gastric disturbance, diarrhœa, anorexia, or vomiting, sometimes persistent. Vertigo and hyperæsthesia may occur in each kind of seizure, but soon subside. The temperature rises rapidly to 103° or more, and continues high two days; it often lasts three days, seldom five or six. Convalescence is variable. Some feel well as soon as the fever subsides, or the day after. In others the nervous or catarrhal symptoms last for days, or relapses occur sometimes after the fever has subsided. In other accounts the prevalence of catarrhal symptoms is most noted. Sore-throat is also mentioned, and many differ little from the following note written by a lady in London at the same time: "Cannot speak—got no voice; cannot walk—got no legs; cannot sleep—got too much head; cannot lie down—cough too much; cannot sit up—sneeze too much; cannot eat—got too big a throat; cannot write—got nothing to say. Why? Influenza."

The clinical proofs of the identity of the two forms of influenza and of their persistence amongst us in a sporadic form from the last epidemic until now under the name of influenza colds and epidemic catarrh has now to be offered. My "Temperature Observations," part of a continuous series from 1850, at pp. 30–36 (J. and A. Churchill, 1868, and later in "Collected Essays," 1887) show such cases with short incubation period of from a few hours to two or three days, a temperature rising to 102° or 103°, with bronchial catarrh in children, or with herpetic tonsillitis in adults, subsiding on the third or fourth day. At p. 33, herpetic catarrh is named as the sporadic form of influenza. In a subsequent essay on "Incubation Periods," p. 90, it is remarked of influenza that prevailing under two forms, the catarrhal and the herpetic, it comes under the diseases with a short incubation period of from two to three or four days, the catarrhal form being shorter than the herpetic, but that they often give rise the one to the other, and "are really interchangeable." Further, it may be said that influenza attacks beginning with catarrh have merged into the herpetic and more febrile forms; also that the febrile form with acute nervous phenomena has subsided upon the development of catarrhal symptoms. Pains, commonly miscalled rheumatic, often precede catarrh: the aching and soreness following influenza colds are not a mere muscular strain from coughing, but a form of neuralgic tenderness often characteristic of influenza colds. My appointment at St. George's Dispensary furnishes a good means of judging as to the more prevalent ailments of the time. Last winter no unusual increase in bronchial attacks occurred. An increase was perceptible this year in November, but after the first severe cold weather of December, instead of the usual incidence of bronchial catarrh a febrile catarrh, with sore-throat, stiff neck, and general malaise, of sudden ingress but of no long duration, has been common. The more severe and protracted attacks have been seen chiefly among those in comfortable circumstances, where no want of care has in any way contributed to relapse, or to the complications that must be looked upon as incidental to the disease.

Harley-street, W.

ROYAL METEOROLOGICAL SOCIETY.—At the annual general meeting of the Society, to be held at 25, Great George-street, Westminster, on Wednesday, the 15th inst., at 7.15 P.M., Dr. W. Marcet, F.R.S., the President, will deliver an address on "Atmospheric Dust," which will be illustrated by a number of lantern slides.

CASES OF EPIDEMIC INFLUENZA: TREATMENT BY SALICINE.

BY T. J. MACLAGAN, M.D., M.R.C.P.

CASE 1.—Miss E. F——, aged twenty-six, seen Dec. 24th, was seized the day before with shivering, headache, pain in back, and great prostration and slight sore-throat. Went to bed. Looks ill, feels very weak, quite unable to sit up, tongue slightly furred, has slight cold in head, has pains all over, feels "as if every bone in her body was being broken." Temperature 102·2°; pulse 116, feeble. To have twenty grains of salicine every hour for four hours, then every two hours.—Dec. 25th: Has had seven powders since they were ordered; feels much better. Temperature 98·3°; pulse 84. To have twenty grains of salicine every three hours. Made a rapid recovery.

CASE 2.—Mr. V——, aged thirty-seven. Seen Dec. 29th. Ill since yesterday. Feels utterly prostrate; complains chiefly of this and pain in the back. Temperature 101°; pulse 104. Twenty grains of salicine every hour for four hours; then every two.—Dec. 30th: Feels much better. Temperature 98°; pulse 76. Has had nine powders altogether. To continue the drug every three hours for two days; then three times a day for a week. Made rapid and perfect recovery.

CASE 3.—Mr. R——, aged twenty-five. Ill since Dec. 28th. Seen on Dec. 29th. Prostration and racking pains all over. Temperature 101·8°; pulse 80, feeble. Twenty grains of salicine every hour for six hours; then every two.—Dec. 30th: Feels all right; only weak. Temperature 98°; pulse 68. Got rapidly well, but continued salicine for a week.

CASE 4.—Miss M——, aged twenty-seven. Seen on the evening of Dec. 31st. Illness commenced yesterday with shivering, headache, and great prostration; "felt as if her legs gave way under her." Temperature at visit 102·8°; pulse 120. Has great pain in the back and looks very ill. Twenty grains of salicine were ordered to be taken every hour for six hours; then every two hours.—Jan. 1st (twelve hours from last visit): Has had eight powders. Feels much better; only weak and slight pain in the back. Temperature 98·4°; pulse 88. To continue salicine every three hours. Made rapid recovery.

CASE 5.—Mrs. M——, aged twenty-four. Dec. 31st, 9 P.M.: Seized during last night with shivering and headache; feels very weak; has slight cold in head, and a good deal of backache; prostration marked. Temperature 101·7°; pulse 108. Twenty grains of salicine were ordered to be taken every hour for five hours, then every two hours. Jan. 1st, 9 A.M.: Has had eight powders; feels much better. Temperature 98·2°; pulse 76. To have salicine every three hours.—Jan. 2nd: Feels well. Temperature normal. Made good recovery.

CASE 6.—Miss V——, aged eight (daughter of Case 2), seen Jan. 1st. Ill since yesterday. Complains of pain in head and back; is "very tired." Temperature 102·7°; pulse 120. Ten grains of salicine every hour for four hours, then every two.—2nd: Feels quite well. Temperature 98·3°; pulse 80. This child was asthmatic, but no pulmonary trouble arose. Her father's and her case in the rapidity of their cure contrasted remarkably with those of three other children and three servants, in all of whom, with no treatment, the fever lasted three or four days, and the prostration several more.

CASE 7.—Jan. 1st: Mrs. H——, aged twenty-three, taken ill during last night, with shivering and pain in head and back, complains now chiefly of great weakness, pain in back and head, slight cough, and smarting of eyes. Temperature 101·2°; pulse 120.—2nd: Feels much better; pain gone; has still slight cough. Temperature 98·7°; pulse 80. Has slight laryngeal catarrh. Salicine to be taken every three hours. To have a poultice to throat.—3rd: Except for slight cough is quite well. Temperature 98·1°; pulse 70.

CASE 8.—Mrs. L——. Jan. 3rd: Taken ill last night with shivering, followed by headache and pain all over. Looks ill; is very prostrate; complains of great pain in head, back, and limbs, and of sore-throat. Temperature 102·8°; pulse 108. To have twenty-five grains of salicine every hour for four hours, then every two hours.—4th: Much better, but still very weak; is perspiring freely; has no pain. Temperature 98·2°; pulse 80. To have salicine every four hours.

CASE 9.—Charles B——, aged eighteen; shivered during the night of Jan. 2nd. Seen Jan. 3rd at 9 P.M. Is very prostrate, "can scarcely stand"; has great pain in head and back and down the limbs; has slight cough. Temperature 104°; pulse 120, feeble; eyes suffused. To have forty grains of salicine at once, then twenty every hour for six hours; after that every two hours. Ten hours after the commencement of treatment, having taken in that time 180 grains of salicine, the temperature was 98° (a fall of 6°), the pulse was 90, and he felt, except for weakness, quite well. He continues well.

These are not selected cases. I have simply given them in the order in which they occurred. The only cases which I have excluded are those which had been ill for more than one day before treatment commenced. In all the same treatment was given—twenty to forty grains of salicine every hour for three to six hours, then every two hours for a day; after that at wide intervals. In all the cure was rapid, the temperature falling to the normal, and convalescence commencing in all within twenty-four, and in most within twelve hours of the commencement of treatment. In none did any serious complication show itself, and in all recovery was rapid and lasting. The prominent symptoms were shivering, prostration, pains in head, back, and limbs, often very severe. In most there was catarrhal irritation of some part of the mucous membrane of the respiratory passages, but in none was this severe.

The object of this communication is to point out the beneficial action of salicine given frequently and in large doses. It seems to arrest the course of this disease as effectually as it does that of acute rheumatism when given in the same manner. Salicylate of soda I have not tried, because in a disease which has marked depression for one of its prominent features, the administration of that drug in full doses might not be safe. Salicine is quite safe, its only drawback being occasionally a little temporary deafness. The danger of influenza seems to consist in the occurrence of pneumonic and allied complications. If we can arrest its course, we thereby diminish the risk of such complications, and, independently of this, save much time and suffering. Possibly it might be useful as a prophylactic if taken regularly (twenty grains three or four times a day) by the healthy. I am taking it myself—twenty grains three times a day—in this hope.

Cadogan-place, S.W.

NOTE ON AN IMPROVEMENT IN THE USE OF THE HÆMOCYTOMETER.

BY S. MONCKTON COPEMAN, M.A., M.B. CANTAB.,
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IT will be generally admitted that a considerable drawback to the usefulness of the hæmocytometer lies in the alteration which always occurs to a greater or less degree in the corpuscles when the blood has been considerably diluted with any of the fluids which are usually advocated for this purpose; the red corpuscles not infrequently swelling up to nearly twice their usual bulk, sometimes losing their hæmoglobin, which is given up to the surrounding fluid, and, most important of all, becoming practically indistinguishable from the white corpuscles. Gowers has proposed to count the latter by raising the objective slightly out of focus, when he states that the white corpuscles, by virtue of their greater refractive power, stand out clearly from the red ones among which they lie. This method, however, is at best unsatisfactory, and has the disadvantage of being very trying to the eyes so that, having occasion to use the instrument pretty frequently, I searched for some means of distinguishing them more readily. It seemed to me that the simplest method of doing this would be to use some dye, which, while staining the white corpuscles, would leave the red untouched. Numerous stains were tried, mostly the aniline dyes, because of their greater rapidity of action, and after a considerable number of trials, methyl violet was at last fixed upon as being apparently that which was best suited for the purpose. Up to this time I had always used Gowers'

solution, and to it the dye was added in varying proportions, the resulting coloured fluid being then used for diluting the blood prior to its examination in the cell of the hæmocytometer. Further experiments, however, appeared to show that Gowers' solution might be with advantage replaced by a much less concentrated solution of sodium chloride, the fluid I now use being made up as follows:—Saturated alcoholic solution of methyl violet, 1 c.c.; normal saline solution (NaCl ·75 per cent.), 100 c.c. This forms a stock solution, one part of which, when required for use, is to be diluted with ten parts of normal saline solution, thus giving a solution of methyl violet of the strength of one part in a thousand. This should be most carefully filtered before use to get rid of any solid particles, and then forms a pale violet-coloured solution, which, when seen in a three-quarter inch test-tube, readily allows the passage of light through it. This fluid is used in a precisely similar manner to those usually recommended, the blood being mixed with it in the small glass pot supplied with the instrument (supposing it to be Gowers' pattern), and a drop of the mixture placed in the centre of the cell. It is then covered, and the springs fixed in place, after which it must be set aside for a few minutes (two or three being usually sufficient), when the corpuscles will be found to have settled on the floor of the cell. The white corpuscles can now be distinguished from the red with the greatest ease, as they will be found to have taken on the stain, which is not the case with the red. At the same time the fluid is of such a degree of dilution that the field of the microscope is not perceptibly tinted.

The various solutions generally employed for the dilution of the blood—such as Gowers', Potain's, and Keyes', of which the first two contain a considerable quantity of sodium sulphate—have apparently been devised with the idea of obtaining a fluid as nearly as possible of the same specific gravity as the plasma; but this advantage, which, I believe, is apparent rather than real, is more than counterbalanced by the fact that the large amount of salts present must cause an alteration in the appearance of the corpuscles. On the other hand, the solution I propose does not appear to cause any such alteration, the small percentage of the aniline dye being quite inoperative in this respect, while the corpuscles sink in it all the more readily from its low specific gravity. The staining of the corpuscles is also of great advantage, particularly when examining blood from a case of leucocythæmia, for instance, in which it is desirable to determine from time to time as accurately as possible the absolute number of white corpuscles present and their relative proportion to the red. Indeed, I feel sure that after a fair trial it will be generally allowed that the use of the coloured saline solution reduces the labour of an observation by at least one half, at the same time that it renders the results much more reliable.

It not unfrequently happens that it is by no means easy to make out the squares on the floor of the cell, and it has been proposed to rub in the scrapings of a soft lead pencil so as to show them up better. If this be done, one is very liable to find large particles lying on the squares, which are not easily got rid of without at the same time removing the finer particles from the lines, so that it would be much better to use some substance which is always at hand in the laboratory, and which is already in the form of an impalpable powder. One of my assistants, Mr. Hallam, suggested the use of carmine for this purpose, and we found on trial of it that it answered the purpose admirably. A few grains should be placed on the floor of the cell, and then gently rubbed in with the end of the finger, when on examination with the microscope the squares will be seen to show up most beautifully, and if at the same time the solution proposed above be used the enumeration of the corpuscles becomes simplicity itself.

York-road, S.E.

BRISTOL DISPENSARY.—The report to be submitted to the annual meeting of the Bristol Dispensary managers will show that it has been carried on very efficiently, and that the number of patients has increased since 1888 by 752. Subscriptions by *employés* of large firms have also increased, the private subscriptions remaining at the same level as in previous years. The committee also report with pleasure a donation of £20 from Mrs. Goss in aid of patients sent to convalescent homes. The legacy of the late Mr. William Thompson has now been handed over to the treasurer, in securities and cash, for investment.

HYPNOTISM IN THERAPEUTICS WITHOUT SUGGESTION.

BY DR. H. C. WOOD.

DURING a recent visit to Paris I spent some little time studying the results obtained, both in the clinic of Dr. Luys and in the private practice of certain physicians who had much faith in hypnotism, and became convinced that valuable therapeutical results were reached. It seemed to me, however, that all the physicians were approaching the practice with their minds completely controlled by the theory that the cause of the cure was the suggestion. Precisely as Dr. Tuckey entitles his recent work on psychotherapeutics "The Treatment by Sleep and Suggestion," so do the observers whom I saw all believe that the suggestion produces the relief.

The accepted theory may be stated in a few words as follows:—That suggestions made during the hypnotic state are capable, not only of affecting the actions of the individual during the hypnotism, but also of affecting the functions of organic life so as to alter a diseased process without the patient being conscious that any suggestion has been made.

My attention was at once arrested by the absence of control experiments, and upon my return to Philadelphia I determined to try the therapeutic effect of hypnosis without suggestion. My observations further led me to the conclusion that the good results achieved were usually in hysterical cases. I had the pleasure of examining the man who was shown to the Paris Academy of Medicine by Professor Luys as a case of paralysis agitans. There can be no doubt that the man was cured of violent tremors, simulating paralysis agitans. The whole history of the case and the appearance of the man lend, however, great probability to the view that the tremors were not those of paralysis agitans, but a hysterical mockery of that disease. I found in my wards of the University Hospital two cases, one closely simulating the tremors case of Professor Luys, the other a sufferer from paraplegia, which I thought suitable subjects for hypnotic therapeutics. The history of the tremors case was that some years previously the woman had been attacked by tremors like those now present, but had recovered after three years' illness; that about three months before entering the ward of the hospital the tremors had returned. They had stopped at one time for two weeks, but at my taking charge of the case were continuous in one arm, and exactly simulated those of true paralysis agitans. I found this woman to be a good subject for hypnosis, and was especially interested to notice that the tremors continued during the hypnotic sleep. No hypnotic suggestions whatever were made to her, but the second treatment was followed by great lessening of the tremors, and four treatments sufficed for a cure. In the second case the paralysis of the legs was almost complete, associated with irregular patches of anæsthesia on the legs, absolute loss of the patellar reflexes, and great complaint of weakness and numbness in the arms. The woman had not the appearance of being hysterical, but the diagnosis of hysterical paraplegia had been made by my assistant, Dr. Dercum, who had charge of the wards during my absence. The ordinary treatment had been instituted without avail. During the hypnotic treatment no suggestions were made to the patient. After the second *séance* the numbness disappeared from the arms; after the third the woman was able to stand; after the fifth she could walk. After eight treatments she was able to walk long distances, stand very well on one leg, and was about to go from the hospital as cured, although her knee-jerks had not returned. I do not propose to commit myself to any theory as to the method in which hypnosis produces cure, although as yet I do not see why all the effects obtained cannot be accounted for by the theory of mental influence. For the exertion of such influence it is not essential that the physician should speak to the patient specifically about his or her case; especially is this true at the Paris and Nancy clinics, since the whole atmosphere is heavy with faith. The patients come to be cured of their diseases; they undergo a process which to the ignorant is most mysterious, and which even educated people must, until they are accustomed to it, look upon as "uncanny." The elements of profound mental impression are all present, and it needs no words of the physician to bring them into action.

University of Pennsylvania.

ON THE IMPORTANCE OF THE PRACTICE OF WASHING OUT THE PERITONEAL CAVITY AS A MEANS OF SECURING A NATURAL DISPOSITION OF THE INTESTINES AFTER AN ABDOMINAL SECTION.

BY JOHN D. MALCOLM, M.B., F.R.C.S. EDIN.,
ASSISTANT SURGEON TO THE SAMARITAN FREE HOSPITAL.

THE practice of washing out the cavity of the peritoneum after an abdominal section has been resorted to with increasing frequency during the last few years, and by some surgeons I understand that it is now employed in all cases. It is not at present my intention to enter into any discussion of those advantages which have been claimed for this method of treatment, or of the objections which may be urged against it. But I wish to direct attention to a mode in which washing out the peritoneal cavity may act beneficially, which has not hitherto, so far as I am aware, been described or had its importance recognised.

In a paper[1] read before the Royal Medical and Chirurgical Society in October, 1887, I showed how paralysis of the intestine is a most potent factor as a cause of death after abdominal section, and that symptoms due to this condition have been confounded with those due to peritonitis. About a month after the reading of this essay, Professor Olshausen read a paper before the Obstetrical and Gynæcological Society of Berlin, in which he also described paralysis of the intestine, or "pseudo-ileus," as a "hitherto unrecognised cause of death after laparotomy."[2] Six months later in the *Revue de Chirurgie* for July, 1888, M. Verchère gave a description of the symptoms due to "septicémie intestino-péritonéale" following abdominal section, which he said originates in paralysis of the intestine; and he further declared that this condition had always been confused with peritonitis. "Le diagnostic est évident dans la plupart des cas, et il était nécessaire de distinguer cette entité morbide de la péritonite avec laquelle elle a toujours été confondue."[3] Other surgeons have recognised clinically the evils of retention of the contents of the alimentary canal in these cases. Lawson Tait has long advocated the advantages of clearing the bowels "on the slightest indication of peritonitis after ovariotomy."[4] He declared that he cured peritonitis by this treatment. In 1887, before my paper on this subject was read, but after it was complete and in the hands of the secretary of the Royal Medical and Chirurgical Society, Dr. Gill Wylie wrote in the *New York Medical Record*[5] "that the tympanites and vomiting, and other symptoms supposed to be due to septic peritonitis after laparotomy, are best overcome by enemas, and if these fail, by a quick purgative; that in these cases, at least, the bowels should be moved and not kept constipated, as has been generally practised; that it is probable that in many cases the persistent and exhausting vomiting may be the direct result of intestinal obstruction, the result of bands of adhesions constricting the intestine." Recently, Dr. William Duncan, in reporting a case of Porro's operation in THE LANCET,[6] has written as follows: "The subsequent progress of the case is most interesting, and teaches a valuable lesson as to the dangerous condition produced by tympanites—a condition which simulated general peritonitis so closely that I was on the point of reopening the abdomen and washing out its cavity. It will be noted that the pulse and temperature steadily increased, whilst the abdomen became more and more distended, until on the third day the condition was most alarming; temperature 103·6°, pulse 120; abdomen tight as a drum from tympanitic distension, very tender on pressure, with acute paroxysms of pain and yet no peritonitis, and all the symptoms and signs at once relieved by the passage of a stiff tube" through the rectum into the colon, and the drawing off of "an immense quantity of flatus."

There is now, therefore, abundant and influential support for my original statement that in paralysis of the bowel following abdominal section "may be found the explanation of many symptoms and of not a few deaths hitherto unexplained or erroneously attributed to inflammatory and other causes."[7] But in the paper to which I have referred I gave a prominence to obstruction of the bowels, nearly, if not quite, equal to that of paralysis of the gut, as a cause of the symptoms in these cases. There is always some obstruction combined with the paralysis when danger arises. The peristaltic energy of the bowel, as I wrote in 1887, may be so weakened as a consequence of its exposure and manipulation that "a very slight impediment to the downward passage of its contents, which would be of no consequence whatever during health, may lead to the most disastrous results. It would even appear that at this time such natural obstacles as exist at the anus, and in the friction of the more solid fæces which accumulate in the rectum and colon, may be the cause of a fatal obstruction."[8] Moreover, there can be no doubt that obstructive conditions may be brought about as a direct consequence of operative proceedings involving injury to the peritoneum. We know that a healthy raw surface when placed in contact with healthy peritoneum is very apt to quickly and firmly unite therewith. Hence, after an abdominal section, unless all raw surfaces can be so placed that it is impossible for them to come in contact with the intestines, it is of the utmost importance that the relations of the coils of gut to each other, and to the abdominal walls, should be such that no tendency to obstruction of the bowels will be induced if adhesions should be formed. But in the course of an abdominal section it may be impossible to avoid wounding parts of the parietal peritoneum, which must be left in contact with the intestines; or the peritoneum covering the gut itself may be injured. It also frequently happens of necessity or by accident that various portions of the intestine are removed from the peritoneal cavity, or from the positions which they naturally occupy therein. If any considerable lengths of bowel be brought outside of the walls of the abdomen, it is quite impossible for the surgeon, in returning the gut, to assure himself that he does not place the various coils in very abnormal positions as regards each other and as regards the parietal peritoneum. Again, when the peritoneum is cleansed by sponging, much turning over and disturbance of the intestines is necessary, and when a sponge is passed into the deeper parts of the abdomen, on being withdrawn, it is very apt to bring forward one or more coils of intestine with it. If portions of the bowel which have been disturbed in these or in other ways should remain in their displaced positions, and become adherent when so displaced, a troublesome or fatal obstruction may be brought about.

On thinking over these things, it has occurred to me that in the practice of washing out the peritoneal cavity we have an important means for promoting a natural adjustment of the intestines, and so avoiding the dangers of obstruction of the bowels in these cases. For if, in finishing the process of washing out the peritoneum, the abdominal cavity be distended with fluid, the intestines must be floated up towards the highest level of the cavity. As the intestines are thus buoyed up by the fluid, it is obvious that changes in the relative positions of the various coils must be greatly facilitated, while the traction which is at the same time brought to bear on the mesentery must tend to straighten out that membrane in the direction between its attachments to the posterior abdominal wall and to the bowel, and so to undo any acute twists which may exist in it. The mesentery and bowel will thus be thrown into natural folds. If the fluid be then simply permitted to flow out of the abdominal cavity, or be carefully sucked out of the pelvis by means of a tube, without any sponging or other mechanical disturbance, the intestines will tend to settle down in a natural position, just as they do when an ascites is relieved by tapping. In no other way can so satisfactory an adjustment be assured. It seems to me, therefore, that one of the most important, if not the most important, of the advantages to be secured by the free use of fluids in cleansing the peritoneal cavity is the facility which this

[1] On the Condition and Management of the Intestine after Abdominal Section, considered in the light of Physiological Facts. (Med. Chir. Trans., vol. lxxi.)
[2] Centralblatt für Gynecologie, January, 1888; and Brit. Med. Jour., May 19th, 1888, p. 1073.
[3] Revue de Chirurgie, July, 1888, p. 576.
[4] Brit. Med. Jour., May 15th, 1886, p. 921.
[5] March 19th, 1887, p. 319.
[6] Jan. 5th, 1889, p. 18.
[7] Loc. cit., p. 66.
[8] Loc. cit., p. 49.

method of procedure affords for securing a natural disposition of the coils of the gut. A normal position being thus obtained, adhesions may form without giving rise to any unpleasant consequences. For adhesions, in themselves, are not necessarily causes of obstruction of the bowels. I have seen extensive adhesions at a second abdominal operation in a case in which no special difficulty occurred during convalescence from the first abdominal section, the first operation being a very severe proceeding, and from it the adhesions had undoubtedly dated. I have also seen the whole of the small intestines so matted together that they were mistaken for an ovarian tumour, for the removal of which the peritoneum was opened, and yet no very prominent sign of obstruction existed. It is therefore only adhesions which fix the gut in unnatural situations that are to be dreaded as a cause of obstruction.

Of interest in connexion with the consideration of the normal arrangement of the intestines in these cases is the assertion that patients who suffer much from chloroform vomiting after an abdominal section not infrequently recover more satisfactorily and more quickly than those who are not so affected. This was first pointed out to me by Mr. Knowsley Thornton, and many illustrative cases have brought the statement to my recollection since. I would suggest as an explanation that if a patient be constantly straining and retching for five or six hours or more after an operation, however much the intestines may have been displaced, the shaking of the abdomen must tend to bring them into a natural position again before adhesions can take place or become firm. If, on the other hand, there be little or no vomiting, and if the patient lie quiet, adhesions may form so as to fix the more or less paralysed intestines in the position in which they have been placed, and so left, by the hand of the surgeon, which, as we have seen, may not be a natural one. This explanation of the way in which vomiting may act beneficially after an abdominal section is not a new idea. For in "A Compleat Body of Chirurgical Operations," published in 1702, after the directions for reducing the gut in penetrating abdominal wounds, it is remarked that "there is no necessity of shaking the body, as the ancients did, to restore the guts to their place, Nature taking sufficient care in this affair."[10] I have endeavoured to show how succussion may be not without advantages after an abdominal section, but of course I do not propose that we should resort to the practice of "the ancients" of "shaking the body" in these cases. On the other hand, I cannot agree with M. de la Vauguion that Nature is to be trusted to take "sufficient care in this affair." Undoubtedly she often succeeds in effecting a satisfactory result; but we must help her all we can. And it seems to me that in the practice of washing out the peritoneal cavity, if conducted as I have described, we have a very efficient means, at the very outset, of restoring the intestines to their natural position in the peritoneal cavity.

I am led to publish these remarks because a largely increased experience of abdominal surgery tends more and more to convince me of the supreme importance of securing a natural disposition of the intestines after an operation involving interference with the peritoneum, so that the lumen of the gut may be as free as possible, and there may be no increase of opposition to the weakened peristaltic contractions. This is desirable not only to secure the immediate recovery of the patient, but also to prevent after trouble, for there can be no doubt that the difficulties with the bowels, the constant or intermittent pains, and other unsatisfactory conditions which sometimes arise in patients who have undergone an abdominal section are not infrequently due to peritoneal adhesions fixing the intestines in unnatural positions.

Bryanston-street, W.

[10] A Compleat Body of Chirurgical Operations, containing the whole Practice of Surgery, with Observations and Remarks on each Case, &c., by M. de la Vauguion, M.D., and Intendant of the Royal Hospitals about Paris, the second edition, faithfully done into English. London, 1702, p. 25.

FOOTBALL CASUALTIES.—On the 1st inst., a youth named Savage, aged fourteen, living with his parents in Queen-square, Bristol, while playing football with companions in the square slipped and broke his leg.—The football accident to Lieutenant Lyon, noticed in our last issue, terminated fatally on Sunday last. He never recovered consciousness. The cause of death was concussion of the brain and internal hæmorrhage.

REPEATED RECURRENCE OF INTUSSUSCEPTION OF THE BOWEL; REDUCTION BY THE HYDROSTATIC METHOD.

BY F. ROWLAND HUMPHREYS, M.R.C.S., &c.

IN THE LANCET of Oct. 27th, 1888, I published two cases of intussusception of the bowel. The first of these has kept in good health, the second has had two repetitions of the complaint. These two attacks being somewhat different in symptoms, I will first give an account of them and then compare the three together.

The child, a boy aged sixteen months, was taken ill on March 16th, 1889, with vomiting and pain in the stomach, the bowels being moved half an hour later. The stools were brown in colour, and soft in consistence. At 1 P.M. some blood passed per rectum, and again a few minutes later. The child continued vomiting all night, seemed better the next day, but at 7.30 P.M., after another attack of vomiting, with passage of slime and blood by the bowel, when nothing could be discovered in the abdomen (though there was dulness from one inch below the umbilicus to the pubes) I examined per rectum, and made out a mass of intestine high up. This did not move with the rectum when the child strained down, but did so every now and then with certain movements. The finger was covered with dark clotted blood and bad smelling mucus. A No. 8 gum elastic catheter was now attached to a Higginson's enema syringe, filled with a very weak solution of boracic acid in warm water, and passed for two to three inches into the rectum—as high as it would go. The jug containing the solution was then raised as high as possible short of straining down on the part of the child, the level of the water being twelve to fourteen inches above that of the anus. Pressure was kept up for fifteen minutes, and again after ten minutes' interval for fifteen minutes more, the catheter being passed in for nine inches during the last injection. At first very little fluid passed into the bowel, but when the hips were raised it went in much more readily. When the catheter was passed in on the last occasion the child was turned on his right side, and then, in turn, the hips were lowered, and then the shoulders were raised eight to ten inches, as high as possible short of the return of the injection, so as to add the action of gravity to the weight of the water in assisting the reduction of the bowel. After about sixteen ounces had passed in the child seemed much easier, but the injection was continued up to a pint. During the second injection examination showed the rectum empty of bowel; at its termination the abdomen was dull up to the umbilicus. A pad and bandage were then applied, and the child quickly went to sleep. One minim of tincture of opium every two hours with some ipecacuanha wine was ordered, and all milk directed to be peptonised. At 5.30 A.M. I was again called to the child, and found it nearly as bad as before. It had been all right up to midnight, when the mother had removed pad and bandage as they had got soiled. Pain had then recommenced. A further injection of one pint of water was given, and after this there was no more trouble. On the 19th the bowels were moved at 1 P.M. Dentition was going on.

The third attack occurred on May 24th. At 6.15 P.M. the child was sick, and had pain in the stomach. The bowels acted at 6.30, and again at 8.30, a little blood passing on the last occasion. At 9 P.M. he vomited some blood. At 9 45 P.M. I found blood and mucus in the rectum, and dulness in the same region of the abdomen as on the previous occasions. I at once injected in the same way as before a pint and a half of a very dilute solution of boracic acid in warm water, the child being in an extreme state of collapse. There was no difficulty about the injection, the level of the water being eighteen inches above that of the anus, a pad and binder being applied as before. A little later he vomited half a cupful of clotted blood, some passing from the bowel also. Next morning there was a little motion on the diaper. Recovery was only interrupted by a relapse in pertussis, which he had previously lost.

This case is a very remarkable one in many ways, and not least in the fact of so young a child getting over three attacks. The recurrence may perhaps be explained by the laxity of the mesocolon (shown by the displacement of the transverse colon), assisted by the constipation from which

the child had suffered since his birth. Each attack occurred while the child was teething. The sausage-shaped tumour was noticeable by its absence—dulness in the lower part of the stomach being the only alteration there,—possibly it would have appeared later, when the ensheathed intestine had become greatly swollen from the constriction at its neck.

I note that the vomiting and the pain always appeared simultaneously as the first signs, and that the flow of blood appeared latest in the mildest attack. In the first attack only a few minutes intervened, in the last (the next severest) two hours and a quarter, and in the second (the least severe at the onset), four hours and a half. The expression of relief shown in the child's face seems to be a good sign as to when the bowel is reduced, though in doubtful or relapsed cases it is as well to fill the abdomen with water, short of pain to the child. The method of treatment which I have described above, and called the "hydrostatic method," seems as good and as easy of application as any, with the additional advantage of being under perfect control, straining down on the part of the child being the indication for lessening the pressure by lowering the vessel of water. Application of a pad and binder certainly affords comfort to the child, and seems to be of service in steadying the bowel and reducing peristaltic movement.

Queen's-crescent, Haverstock-hill, N.W.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

THE INFLUENZA EPIDEMIC.

By H. W. G. MACKENZIE, M.D.

THE following notes of cases seen on Jan. 1st, 1890, among my out-patients at the Royal Free Hospital may be interesting. It will be observed that seven of the nine cases are men. All have been attacked more or less suddenly, and the principal symptoms are the same in all.

CASE 1.—G. T——, aged thirty-eight, was taken ill more or less suddenly a week previously to presenting himself at the out-patient department of the hospital, with frontal headache, chilliness, shivering, lumbar pain, and "running" at eyes and nose. Has felt ill all the week, but has continued going about. His temperature was 102°; pulse 92; and the spleen slightly enlarged. Bowels constipated. On Jan. 4th, when seen again, his temperature was 100·2°, and he had sneezing and "running" at the nose.

CASE 2.—Thomas A——, aged twenty-two, was taken ill suddenly on Dec 30th, with sore-throat, catarrh, frontal headache, and chilliness. His temperature was 102°; pulse 100. No splenic enlargement.

CASE 3.—Minnie A——, aged twenty, was taken ill on Dec. 31st, with "bad cold," aching and stiffness in legs, severe headache, anorexia, slight cough, but no coryza. Temperature 103°; pulse 134. Great depression of spirits. On Jan. 4th convalescent, but temperature still 99·8°. Brother now affected.

CASE 4.—George B——, aged thirty six, was taken ill "all of a sudden" on Dec. 28th when at work. He felt as if his legs would give way under him. When he got home he was seized with giddiness, and had shivering and sweating; was sick; had pains in jaws. Has kept his bed since, but cannot sleep. Temperature 99°; pulse 80. No enlargement of spleen.

CASE 5.—Harry M——, aged nineteen, was taken ill on Dec. 30th with pains in loins, thighs, and top of head, and giddiness. Has felt very ill since and has kept his bed. Now looks ill, face flushed, conjunctivæ injected, and there is "running" at the nose and eyes. Temperature 103·5°; pulse 136. No splenic enlargement. He was admitted. The evening temperature was 105·2°. He continued ill four days, the temperature gradually subsiding, but rising to 104° again on Jan. 3rd. Great drowsiness and cough, with much expectoration.

CASE 6.—Florence B——, aged five, was taken ill on Dec. 31st; pains all over, feverish all night, sleepless. Temperature 101.° Convalescent on Jan. 4th, but sister and many others in same house ill.

CASE 7.—Philip B——, aged eighteen, was taken ll suddenly on Dec. 31st, at 4.30, with giddiness, pains in head, and coryza. On Jan. 1st his face was flushed and the conjunctivæ much injected. Temperature 103°; pulse 104. He looked and felt very ill. On Jan. 4th only weakness and constipation. Temperature normal.

CASE 8.—William I——, age nineteen, was taken ill suddenly on Dec. 30th, about 11 P.M., when about to go to work, with giddiness, dryness of mouth, vomiting, cold shivers, pains in the chest, and "running" at the nose. Temperature 101·8°; pulse 100.

CASE 9.—John J——, aged twenty-eight, was taken ill on Dec. 30th with pains in the limbs and running at the nose. Now tongue furred, no giddiness, no sickness. Temperature 101·5°; pulse 128. On Jan. 4th only weakness remaining. Temperature normal.

Lambeth Palace-road, S.E.

ANTIPYRIN IN DYSMENORRHŒA.

By JOHN WAUGH, M.A., M.D.

PAINFUL menstruation is a condition so common and so distressing that no apology is required for bringing into prominence any drug which is found to contribute to its palliative or curative treatment. Having recently noted highly satisfactory results from the administration of antipyrin in several instances where little or no benefit followed the use of morphia, belladonna, spirits of chloroform, apiol, &c, I append the following details concerning the most severe of those cases. Relief, more or less complete, was obtained whenever antipyrin was used, but I do not propose to give particulars of the less typical cases.

A. H——, unmarried, aged twenty-six, consulted me on April 25th, 1889. She complained that for ten years past—almost since her first menstruation, which was at the age of fifteen—she had suffered excruciating pain before, during, and after each monthly period. Of recent years her sufferings had gradually become more severe; for a week in every month she was confined to bed, but was unable to sleep except in unrefreshing snatches. The pain was so acute that she several times while in bed fainted away. She had invariably for two days violent retching and sickness, which were so severe that on one occasion she ruptured one of the conjunctival bloodvessels; this was treated at Moorfields Ophthalmic Hospital. The flow lasted usually four days; the pain began two days before, and persisted till one or two days after. When the period was over there remained great pain in the right hip and thigh; though not sufficient to lay her up, this pain caused lameness, considerable at first, but gradually becoming less during the nine days it lasted. An unusual symptom was a desquamation of the fingers, which began two or three days after the close of each period; the skin of the fingers of both hands peeled off, and deep transverse fissures, which sometimes bled, appeared on the palms of the hands and on the palmar aspect of the fingers. The patient's relatives and friends assure me that the above symptoms are not exaggerated, and that the girl is hard-working, sensible, and patient in her sufferings. On April 25th I prescribed six powders, each containing 10 grains of antipyrin—one powder to be taken every four hours, dissolved in a little water. Menstruation began on April 27th, and lasted till the 30th. As a result she had no sickness (the freedom from which she considered a great boon) and much less pain, but there were still the lameness and the desquamation, the latter of which I had an opportunity of seeing. Vaginal examination showed acute anteflexion, a conical cervix, and a small os. The introduction of a pessary relieved bladder symptoms, of which she had complained. For the low state of her general health resulting from her periodical compulsory starvation I prescribed ferri et ammon. citr., liquor arsenicalis and glycerine, with pil. al. c. ferro. Menstruation began again on May 28th, and for this period she had eight 10-grain powders. On the first day the pain was severe, and she used her antipyrin rapidly. As she did not get a further supply, the relief was not so complete as it might have been, and there were again some lameness and desquamation. Menstruation took place on June 27th to 29th. As 60 and 80 grains given in frequent ten-grain doses had produced

no bad effects, I instructed her to take the antipyrin in larger doses and oftener. This she did with complete success. She took 150 gr. as follows:—20 gr. on June 26th at 9 P.M.; June 27th, 20 gr. at 9 and 1, and 10 gr. at 6 and 11; June 28th, 10 gr. at 8, 12, 4, and 11; 29th, 10 gr. at 10 and 10; 30th, 10 gr. at 10 P.M. only. During the period she was not laid up; she had no pain or sickness; she went about housework as usual; was able to go out of doors; had afterwards no lameness and no desquamation. For the period, July 23rd to 26th, she used 150 gr. with the same result; and 100 gr. at the August menstruation acted so satisfactorily that she described it as the best time of all. During the September flow she was able to assist her sister in a busy fancy stationery retail business. Menstruation passed off so well on Oct. 22nd to 24th that 80 grs. sufficed to prevent the symptoms.

Her general health has much improved, and this fact, with the smaller amount of antipyrin now required, encourages the hope that the improvement may be permanent.

Wimpole-street, W.

ALUM ENEMATA IN DYSENTERY.

BY HENRY F. NORBURY, C.B., M.D.,
DEPUTY INSPECTOR-GENERAL, ROYAL NAVY.

(Communicated by the Medical Director-General of the Navy.)

HAVING read in THE LANCET of Aug. 31st a paper by Mr. Hepburn on the successful treatment of an obstinate case of dysentery by strong enemata of alum, I was induced to try it in the following case, and with such success that I think it advisable to report it, in order that attention may be drawn to Mr. Hepburn's method. A seaman, aged thirty-one, had contracted dysentery abroad three years and a half previously, and since that time had never enjoyed his usual health. He had frequently suffered from tormina, had from three to ten loose offensive stools daily, accompanied by much tenesmus and by occasional passages of blood, and he had gradually become feeble and emaciated. During this long period he had frequently been under treatment, but with only slight benefit. He was unable to continue his duties on board ship, and had to return to England, when he came under my observation. His appetite was bad, his tongue foul; he passed, amid much straining, from three to eight loose, frothy, offensive motions daily, sometimes containing blood; but, although griping pains were often very distressing, there was neither tympanites nor abdominal tenderness. e was carefully dieted, and among the drugs prescribed for a long period were compound ipecacuanha powder, aromatic sulphuric acid, decoction of hæmatoxylon, lead pill with opium, compound kino powder, chlorodyne, sulphate of copper pill with opium, and liquor ferri pernitratis, besides enemata of opium, of nitrate of silver, and of sulphate of zinc, and suppositories of tannin. I can fairly say that he derived no benefit whatever from any of the above. Lastly, I prescribed an enema containing half an ounce of alum in ten ounces of water, to be administered night and morning. It produced slight sweating at first, but the effect in a couple of days was remarkable; the stools were reduced to one or two daily, and shortly became of natural consistence. This treatment was continued for eighteen days, when the patient expressed himself as feeling better than he had done for years; he had also gained considerably in weight and looked robust. He was kept under observation for some days after the enemata were stopped, to ascertain if there would be any return of his complaint, but as there was none he resumed his ordinary avocations.

Plymouth.

THE EFFECTS OF THE ELECTRIC CURRENT WHEN APPLIED TO THE FEMALE PELVIC ORGANS: A FEW EXPERIMENTS.[1]

BY W. K. M'MORDIE, M.D.,
SURGEON, SAMARITAN HOSPITAL FOR WOMEN, BELFAST.

IT is now only a few years since the application of electricity as a therapeutic agent had almost entirely fallen into the hands of quacks. Apostoli has by his energetic efforts prominently brought electric therapeutics before the profession and the public, as applied to the treatment of uterine fibroids. The facts adduced and proved by him and others who have been engaged in these experiments are very few. This being so, any ascertained effect of the electric current passing through any organ either in physical change or physiological action is worthy of being recorded and placed before the profession. A few years ago I got a one-celled electric battery, and for some months made a series of observations on the effects produced in uterine hæmorrhage when the cause was obscure, and in fibroid tumours. I applied it as follows: One pole attached to a conductor in the form of a uterine sound placed in the uterus, and the other to a flat conducting surface placed over the abdominal parietes, corresponding to the fundus uteri. Two effects were produced when the current was passed from ten to twenty minutes. In cases where the external os was small it became dilated, and in a large proportion of the cases where the females were healthy the sexual orgasm was produced. It had no effect on the fibroids even after frequent applications. It made no difference whether the positive pole or the negative pole was inserted. The current was constant, and I had no means of measuring it except by the sensations of the patient. It may be said that my battery was too simple and my mode of application not on scientific principles. Nevertheless, I have seen enough to convince me that an electric current passed through the pelvic organs of a female in a fairly healthy condition will in a large proportion of cases produce what I have stated It has been said that the electric treatment sometimes causes intra-uterine fibroids to extrude from the external os; but this frequently takes place without the aid of electricity. Soft fibroids frequently get smaller without any treatment. Hygienic and dietary treatment frequently relieves symptoms connected with fibroids. But mistaken diagnosis will in some cases, at least, account for the disappearance of a supposed fibroid. The following might have been such a case: A lady came under my care as a private patient in the Samaritan Hospital during the past summer suffering from an abdominal enlargement, which was circumscribed and flattened, about the size of an adult head. She first noticed it about two years previously, and she then placed herself under the care of her family physician; it, however, continued to grow, and at the time she came under my care it certainly might have been reasonably mistaken for a fibroid. During the two years previously to her coming under my care she had consulted two of the leading physicians of the city, and both considered it an organic tumour. When I first saw her she said she would not have an operation performed, but would submit to any other form of treatment. A full enema with an eight-inch pipe proved the tumour to be an accumulation of hardened fæces. What effect electric puncture would have had on this mass it is impossible to say; but certainly had it disappeared under such treatment it would have been counted as a fibroid cured by electricity.

Belfast.

[1] A paper read at a meeting of the Obstetric Section of the Royal Academy of Medicine in Ireland on Nov. 22nd.

RELAPSING ERYTHEMA OF FACE.

BY TOM ROBINSON, M.D., F.R C.P.

M. H——, aged forty-seven, said she had been subject to erysipelas of the face for many years; that her mother also suffered. The attacks have come on at all times of the year, but she thinks more in the winter than during the summer. She feels quite sure that a sharp current of cold air blowing upon her face would light up the inflammation, and on two occasions it has been caused by riding in a train with her face to the engine and the window open. She believes she first had an attack when she was twenty-three years old. I saw her on Feb. 3rd, 1889. The weather was very cold. Two days before she had been out for a walk, and she felt the cold strike her face as if something sharp had been thrown at her. During the evening the bridge of the nose and cheeks felt hot, and she was convinced an attack was coming on. On the second day she remained indoors, and the swelling increased. When I saw her she looked at the first glance exactly like a patient with facial erysipelas. The eyes were nearly closed, the outline of the nose was lost, and there were several vesications. I could not discover any wound of the skin, and, what was to my mind of great importance, the contiguous lymphatic glands were not involved. The temperature as taken in the mouth was only 99°. The redness shaded off gradually with the

surrounding skin, and in no place could the margin be said to be abrupt. She complained a good deal of a smarting feeling in the skin, which she compared to the sensation left after the cut of a whip, but she was not in any way out of health. She was ordered to remain in bed, and to apply constantly a lotion of oxide of zinc, spirits of wine, and solution of lead. In six days the swelling had subsided, and the attack was practically at an end. I saw my patient two months afterwards, and then we could see a clumsy look about the features which she was anxious to get rid of.

I think this is only an exalted degree of what we meet with in every-day experience. The degrees of vulnerability of the skin of the face varies as much as the vulnerability of clothing. It is a matter of common experience that the rays of the sun, cold weather, fierce wind, soap, dust, or heat will produce effects upon the facial skin as varied as the sky; probably few of us resist absolutely the irritating effects of the sun's rays, as is evidenced by the bronzing, or blistering, or the bringing out of freckles. If the irritation only produces a simple erythema we hear but little about it, and it succumbs to some simple domestic remedy. If the irritation produces a crop of small vesicles, we designate it "eczema vesiculosum," and it drifts into our hands. If the irritation produces a crop of large vesications or bullæ, with a good deal of infiltration of the skin, we speak of it as relapsing erythema, or, as some would prefer to say, "relapsing erysipelas." The case I have given an account of is one of a common variety.

Prince's-street, W.

A Mirror
OF
HOSPITAL PRACTICE,
BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

LONDON TEMPERANCE HOSPITAL.

CASE OF ACUTE PHTHISIS, TERMINATING WITH RAPID GANGRENE OF FACE AND CEREBRAL ABSCESS; REMARKS.

(Under the care of Dr. EDMUNDS.)

THE phagedænic ulceration of cheek in this case is the point of unusual character to which we would draw attention, phagedæna being a very rare complication in phthisis, but apt to appear in any patient the subject of exhausting disease. In this patient, although only twenty years of age, there was much œdema of the lower extremities independently of organic cardiac disease or disease of the kidneys, indicating considerable exhaustion. The ulceration is also noticeable for its seat and for its extension into the cranial cavity. Opportunities rarely present themselves of watching the progress and ending of these ulcerations. For the report of the following case we are indebted to Dr. Leonard Wilde.

William H——, aged twenty, was admitted to hospital on June 13th, 1889. His family history was bad, his mother and one aunt having died of phthisis. About three months before admission he caught cold, felt weak, and had night sweats. Cough became frequent, and shortly after he suffered from copious expectoration, which latterly had been offensive. He never had any hæmoptysis. On examination, a large cavity was diagnosed in the upper lobe of the left lung, and commencing softening in the right lung. Both legs were very œdematous, and there was an unhealthy ulcer over the inner third of the left leg. Urine acid; no albumen. Tubercle bacilli were found to be plentiful in the sputa. He remained in about the same condition until July 25th, when he complained of toothache, and the right side of his face was somewhat swollen. A carious upper molar was removed, but the swelling increased, and the cheek became red and shiny. On the 29th there was no evidence of fluctuation internally; but to relieve the tense and œdematous condition an incision was made with a knife, which had been carbolised, on the outside of the cheek, and some black sanguinolent fluid escaped, which was highly offensive. A probe was passed into a considerable cavity, left by the evacuation of this fluid, the walls of which were black and glistening. The following day a small black spot appeared near the angle of the mouth, and there was an aphthous ulcer on the corresponding side of the tongue. This black slough quickly spread at its periphery until it finally involved the whole of the cheek. The eyeball became greatly protruded, and there was a swelling above the zygoma, extending over the temporal region. He did not complain of pain, and was quite conscious, but grew gradually weaker, and died on Aug. 2nd.

At the necropsy, the whole of the right cheek was involved in a slough, black in the centre, greenish at the edges, not extending into the mouth, although the buccal mucous membrane of that side was discoloured. The right eye was protruded, and there was subconjunctival œdema obscuring the lower half of the cornea, and when the conjunctiva was incised some purulent fluid escaped. Beneath the scalp the temporal muscle was of a glistening grey colour, and very soft, almost gelatinous. On removing the brain the anterior portion of the temporo-sphenoidal lobe was found to be gangrenous and breaking down into soft shreddy material, and just beneath the grey matter there was a small abscess, containing horribly offensive greenish pus. Scattered over the vessels at the base of the brain were many small yellow tubercles, and around the gangrenous patch was a deposit of recent lymph. The dura mater over the middle fossa of the skull had shared in the same rapidly destructive process, and there was pus on its inner surface. The contents of the right orbit were quite pulpy, and it was impossible to distinguish the different structures. A probe passed through the sphenoidal fissure easily made its way over the lower margin of the orbit into the cavity in the cheek. In fact, the course of the inflammation could be easily traced in two directions, one from the cheek beneath the zygoma to the temporal region, the other along the floor of the orbit through the sphenoidal fissure to the cavernous sinus, spreading thence over the middle fossa of the skull. There was a large cavity in the left lung, and a smaller one in the right. Heart and kidneys healthy; liver fatty.

Remarks by Dr. WILDE.—This case seems to have been somewhat remarkable owing to the uncommon fatal complication of gangrene of the face and the extension of this to the orbit and through the sphenoidal fissure to the temporo-sphenoidal lobe, and also from the rapidity with which the cerebral abscess must have been produced and the absence of any cerebral symptom in spite of an extensive intracranial lesion, though this is not invariably to be expected, as Gowers has pointed out.

ROYAL SURREY COUNTY HOSPITAL, GUILDFORD.

SUPPRESSION OF URINE FOR THIRTEEN DAYS; SINGLE KIDNEY; OCCLUSION OF URETER BY INSPISSATED THROMBUS; REMARKS.

(Under the care of Mr. BUTLER.)

IT is fortunate that Mr. Butler was able to obtain (and record) the post-mortem examination in this case, for it is one of exceptional interest. From old disease the patient was placed in the position of one with a single kidney, and injury to this was therefore of increased gravity; had both been in working order it is possible that this kidney would have become hydronephrotic, the block in the ureter remaining a permanent one, and the exact pathology of the condition unexplained. It may be that this is the condition which obtained where hydronephrosis developed subsequently to injury in some recorded instances. That blood clots of large size frequently pass through the ureter after damage to a kidney followed by hæmaturia is well known, and sometimes the symptoms produced by their passage are of considerable severity, like those caused by the passage of calculi; but evidence of the complete obstruction of a ureter by one of these clots has been wanting. Several examples of anuria, due to blocking of the ureter of the only sound kidney by a calculus, or of the simultaneous blocking of both ureters by calculi are on record, and it is a

most fatal occurrence.[1] In such the surgeon can usually obtain a history to assist him in the diagnosis. Various conditions have caused anuria after injury to the kidneys. Mr. Cock recorded[2] the case of a young man aged eighteen who died comatose on the eleventh day after an accident. Within a few days all the symptoms of the original injury, and of the subsequent peritonitis, had subsided excepting that the catheter withdrew nothing but blood. At the necropsy a ruptured single kidney with other internal injuries was found. In Mr. Poland's case[3] complete suppression of urine followed an injury; the patient lived for six days, and the necropsy revealed thrombosis of the renal vessels of one kidney and rupture of the pelvis of the other side. Dr. Moxon gave an account of the case of a man aged twenty-two in whom nearly complete anuria resulted from an injury to the back, probably from thrombosis of the renal vessels. Ashhurst[4] says that an injury short of actual rupture of the pelvis of the kidney or of the ureter is a strain or laceration of the kidney or ureter followed by adhesive inflammation and obliteration of the urinary duct, with the development of hydronephrosis within a week or two. As illustrative cases he cites that of Mr. Stanley,[5] who treated a boy of nine, and that of Mr. Croft,[6] who successfully treated a boy aged twelve in whom hydronephrosis developed after injury to the kidney. There had been hæmaturia for a period of six days.

A. S——, aged forty-three, labourer, was struck by the handle of a plough in the left lower abdomen. The blow did not knock him down, and though suffering from pain in the back he continued to work for four days after receiving the injury. On the fourth day after the accident sudden total suppression of urine came on, accompanied by rigors, sickness, and violent pain in the back. The patient stated that suppression of urine had been complete for ten days. Until the present attack he had been working in the fields, and there had been no symptoms pointing to renal disease. On admission, the bladder was empty. The breath had a urinous odour, and the abdomen was somewhat distended, and there was tenderness in the epigastrium and flanks. The temperature was 99°, but remained 98° till death. On the day after admission broncho-pneumonia developed, accompanied by hæmoptysis, nausea, vomiting, and diarrhœa. Muscular twitchings were observed during sleep, and the man died on the third day in an attack of general convulsions.

Necropsy.—The blood for the most part was uncoagulated. The bladder was completely empty. The right kidney was cystic and atrophic and weighed 120 grains; it measured one inch and a half in length. The ureter was pervious but thread-like. The supra-renal body was disorganised. The left kidney was much enlarged and bound down by old and recent inflammatory changes, which had involved the atrophied supra-renal body. The ureter was greatly distended with urine, and a solid hard plug could be felt blocking the ureter about its middle. The capsular veins were hypertrophied and engorged. The capsule was very adherent, and the surface of the kidney was mottled with minute purulent collections. On section the radicles of the renal veins were found thrombosed; the thrombi were hard, brown, and gritty, and on first appearance looked exactly like small calculi; when soaked in spirit they became friable, and microscopically they were evidently inspissated blood-clot. A hard brown mass could be seen and felt beneath the mucous membrane of one of the calyces, and near it was a large rent in the softened kidney substance. Through this rent an inspissated thrombus had passed, and, gaining the pelvis of the kidney, become impacted in the ureter. On opening the pelvis several brown hard bodies were observed, and both these bodies and the plug occluding the ureter on microscopic examination were proved to be inspissated thrombi.

Remarks by Mr. BUTLER.—It is probable that the blow in the abdomen was the cause of the thrombosis. The actual cause of death was occlusion of the ureter, for the high tension of the urine distending the ureter indicates that the physiological action of the kidney was not entirely arrested. It is also remarkable that both supra-renal bodies were disorganised, though all signs of Addison's disease were absent.

[1] Estimated mortality 82 per cent.
[2] Guy's Hospital Reports, vol. xiv. [3] Ibid.
[4] Encyclopedia of Surgery, vol. v. p. 879.
[5] Medico-Chir. Soc. Trans., vol. xxvii., 1844.
[6] Clin. Soc. Trans., vol. xiv.

ROYAL PORTSMOUTH HOSPITAL.

A CASE OF INTESTINAL OBSTRUCTION; RIGHT LUMBAR COLOTOMY; RECOVERY; REMARKS.

(Under the care of Dr. T. WARD COUSINS.)

IN the absence of evidence as to the exact seat and cause of obstruction in this case, and for the reasons which are given in the remarks, the colon was opened in the right lumbar region, and the patient effectually relieved. The questions of surgical procedure in similar cases of obstruction of the large bowel have been so recently under the notice of the profession in our columns[1] that we do not purpose to reconsider them here.

The patient was a tall man of full habit, aged sixty-four years. He had been accustomed to heavy work as a railway porter, but he had never had any serious accident or illness. As a general rule his bowels had always acted regularly, but during the last seven months he had been much troubled with constipation. Last June he suffered several days from "stoppage" of the bowels, and the attack was attended with great abdominal pain and vomiting, but the symptoms fortunately at length yielded to large injections of oil and warm water. Another attack occurred in September, and at the suggestion of his medical attendant, Dr. F. Pierce of Southsea, he was removed to the Royal Hospital. On admission the condition of the patient appeared to be very critical, and his sufferings were very distressing. The bowels had not acted for ten days, and the abdomen was very tense and tympanitic. His mouth was dry, and he vomited large quantities of a dirty brown fluid. After the failure of the usual treatment right lumbar colotomy was performed and the intestine immediately opened. The evacuation of a large quantity of soft fæcal matter took place, and relief to the symptoms followed at once. The subcutaneous tissue around the gut had been carefully protected by the free injection of warm lanoline. A few days after the operation fæces began to pass through the canal, and at the end of a month the bowels acted nearly every day, and no fæcal matter passed out of the lumbar opening. He left the hospital in October with the wound healed all but a narrow fistula, through which flatus occasionally escaped. On Nov. 27th, 1889, the patient came to report himself at the hospital. He is now in good health, and has been able to do some light work at the railway.

Remarks by Dr. COUSINS.—The case is an illustration of intestinal obstruction caused by fæcal accumulation. Habitual constipation had weakened the peristaltic movements, and prolonged dilatation of the colon at length terminated in its complete paralysis. In cases of this kind the bowel immediately beyond the distended part has been found firmly contracted, with congestion and inflammatory infiltration of the intestinal coats. Distension and paralysis of a portion of the canal generally occur in patients advanced in age, and the large intestine is the usual seat of the obstruction. At the time of the operation the condition of the patient appeared very unfavourable, but after a careful examination of all the details of the case, right lumbar colotomy seemed to offer the best prospect of relief, and this opinion was based upon the following considerations:—1. The great distension of the abdomen and the early development of meteorism. 2. The negative result of rectal exploration, and the capacity of the lower bowel for retaining large injections of hot fluid. 3. A well-marked localised fulness and resistance on palpation over the umbilical region. This swelling was elastic and not doughy in character. 4. The age of the patient, the clear evidence of constipation for many months, and the absence of other indications of abdominal disease.

[1] THE LANCET, 1889 vol. ii., pp. 1061 and 1211. Mr. Bryant: Bradshaw Lecture.

A MORTUARY FOR THAMES DITTON.—At a meeting of the Kingston Rural Sanitary Authority it was reported that the plans and estimates for the erection of a mortuary at Thames Ditton had been under the consideration of the vestry. The Lord of the Manor had made a grant of a suitable piece of land for £10, and the vestry wished for the sanction of the Sanitary Authority to carry out the work. The board sanctioned the work, the expenses of which, however, were not to exceed £100.

Medical Societies.

PATHOLOGICAL SOCIETY OF LONDON.

Pathology of Duodenitis after Burns.—Intussusception of Jejunum.—Cardiac Calculus.—Ruptured Spleen.

AN ordinary meeting of this Society was held on Jan. 7th, the President, Dr. Dickinson, being in the chair.

Dr. HUNTER read a communication on the Pathology of Duodenitis after Burns. After referring to Mr. Curling's observations made in 1842 in a paper read before the Royal Medical and Chirurgical Society, in which he recorded ten cases of ulceration of the duodenum after burns, he said that there had come to be a widespread belief in the existence of some connexion between injury to the skin and affection of the duodenum, but up to the present time no satisfactory explanation of its nature had been given. Mr. Curling's view that the ulceration of the duodenum resulted from the augmented action of Brunner's glands did not rest on any physiological basis, and the same remark applied to the theory of Drs. Brown-Séquard and Handfield Jones that the lesion was due to sympathetic disturbance. Reports from Dr. Wilks, at Guy's Hospital, and from Mr. Macarthy, at the London Hospital, were valuable in showing the rarity of duodenal ulceration after burns. The object of the present communication was to show that a connexion existed between duodenal lesion and burns, and to give a reasonable explanation of its nature. The results of certain experiments on dogs were recorded, and they were obtained in the course of other investigations involving the study of the behaviour of certain poisons on the blood and the channels of their elimination from the body. The drug employed was toluylendiamin; it was administered subcutaneously in doses of from ·3 to ·5 gramme, and the animals were killed from three to seven days later. The fact established by these observations was that the most intense duodenitis might be set up by the excretion of irritant products through the bile. This would explain not only duodenitis after burns, but also other allied conditions. A dog killed seven days after the subcutaneous injection of ·5 gramme of toluylendiamin, the administration being repeated on the fourth day, showed a normal empty stomach, while the duodenum for a distance of eight inches from the pylorus presented the most marked evidences of inflammatory change; the lumen of the gut being filled with clear mucus derived from the inflamed area. The congestion was greatest in the neighbourhood of the openings of the bile-ducts, and gradually faded away from that point downwards. The whole intestinal mucous membrane was somewhat swollen, and presented patchy congestion. In another experiment, in which the animal was killed three days after the administration of ·3 gramme, there was, in addition to inflammatory congestion, what seemed to be commencing ulceration; but it was found that no actual loss of tissue had occurred, these spots being simply follicular tissue with considerable swelling of the mucous membrane around their margins. In this case there was also much injection of the lower portion of the ileum, which appeared to be due to stagnation of bile-stained fluid in this position. Other experiments gave similar results. In all the cases the only channel by which the poison reached the intestine was through the bile, but whether it was the drug itself which produced the lesion or some products of its own disintegration or of its action on the tissues was not at present determined. The duodenitis thus produced experimentally strikingly resembled that met with experimentally after burns, there being in both inflammatory congestion of the mucous membrane, with or without ulceration, or an appearance like it. The congestion would probably usually pass off in the course of a few days, its longest duration being about seven; while an ulcer formed during this period would be prevented from healing, and later (probably in about two or three weeks) would cause death by eating through the intestinal coats and opening one of the branches of the pancreatico-duodenal artery. Of the tissue changes produced by extensive burns, or the products of those changes, almost nothing was known; but changes in the blood-corpuscles had been frequently observed, and hæmoglobinuria had been often noticed; this, though doubtless in part due to the high temperature, was more directly owing to the action of the products formed from the disintegration of the burnt tissues. To complete the parallel drawn between the action of the products thrown into the blood after burns and toluylendiamin, it was only necessary to add that one of the most marked properties possessed by the latter drug was its power of inducing destruction of the red blood-corpuscles. Though it was necessary to be careful in transferring the results obtained from experiments on animals directly to the case of man, yet it was impossible to overlook the striking resemblance between the lesions induced in the duodenum and the action on the blood in the two sets of cases; and the logical conclusion followed that the cause of the duodenitis of burns, as of the duodenitis of toluylendiamin poisoning, was the excretion of substances irritant in their action, through the bile.—Mr. BOWLBY said that he had found congestion of the duodenum very uncommon after burns, and he had never seen ulceration or hæmoglobinuria.—Dr. COLLINS mentioned some experiments he had performed on guinea-pigs when investigating the action of this drug for Dr. Brunton. It powerfully stimulated the hepatic secretion, but, as a biliary fistula was made, no duodenitis was found.—Sir JOSEPH FAYRER had had many opportunities of inspecting the bodies of persons who had died from burns. He had never noticed ulceration or any special injection of the intestinal mucous membrane.—Dr. PERRY, in making indices of the post-mortem books at Guy's, found no mention of duodenal ulcers from burns.—Dr. HUNTER, in reply, said that the object of his communication was to explain on physiological grounds the possibility of the occurrence of congestion or ulceration of the duodenum after burns. He had remarked on the few records extant of these lesions. As he had not been able to produce duodenitis in rabbits by exhibition of toluylendiamin, he had concluded that the lesion must have been due, not to excretion of the drug itself, but of some disintegration products.

Dr. HALE WHITE showed a specimen of Intussusception of the Jejunum taken from a middle-aged man, who was admitted in too collapsed a condition for operation, but clearly suffering from some form of intestinal obstruction. At the necropsy there was found some recent peritonitis. There was also an intussusception of the jejunum, which commenced 2 ft. 6 in. from the pylorus. The intussusception was ten inches long. All the coats were gorged with blood, and there were some bubbles from decomposition. For an inch above, the bowel was thickened as though it had been included in the intussusception. Inside the bowel was found a hard pear-shaped polypus, which was attached to the inner coat at the most forward portion of the intussuscepted part. It was about three quarters of an inch long, and was pedunculated. This case was very rare, for the intussusception was unusually high up, had occurred in an adult, and was due to a pylorus.

Dr. DELÉPINE showed a specimen of Cardiolith obtained from a female child five years of age, who was taken ill seven days before death with diphtheria. She was three days under observation, and apparently died of cardiac failure. On opening the heart a hard concretion was found in the right ventricle. The other lesions were the usual ones of diphtheria; the larynx was full of thick, tough, and very adherent false membranes. The stone was not the result of the last illness, and it seemed very unlikely that it was the cause of death or seriously accelerated the fatal event. The concretion was situated between the right segment of the tricuspid valve and the inner aspect of the part of the cardiac wall forming the right border of the organ. It extended from the point of insertion of the valve to the bases of some of the small papillary muscles. In shape it was irregularly rhombic and much flattened, its optical section being lenticular. Its longest diameter (obliquely antero-posterior) measured about three-quarters of an inch. The other diameters were from above downwards about half an inch, and from side to side a quarter of an inch. Its inner surface, the one in contact with the valve, was slightly nodulated. The outer surface was smooth, except at four places near the posterior end of the stone, where it was adherent to the endocardium through four short fibrous-looking bands. The mass was of a yellowish-white colour, and looked like a small piece of bone covered with a distinct, smooth, glistening membrane, continuous through the fibrous adhesions with the endocardial membrane. The concretion felt hard, but in some places was distinctly elastic, as if the hardness were due to the presence of a thin shell of bone. The internal parts were rather soft and

granular. On microscopical and chemical examination it was found that the concretion was composed of four concentric strata. One stratum consisted of an external layer of laminated endothelium, very thick in the neighbourhood of the adhesions, thin elsewhere. The superficial layers of this coat were composed of well-formed endothelial cells, staining well with ordinary reagents. The deeper layers were less distinct, stained badly, and were partly calcified. The next coat was much thicker, and was apparently composed entirely of rounded masses of carbonate of calcium; at places it was evident that this material had been deposited in the midst of laminated fibrous tissue, resembling the deep layers of the endothelial stratum. In the other regions were deeply-situated débris of fibrin, and brown pigment could be recognised with some difficulty. More internal still there was an irregular layer composed of more or less crystalline and transparent masses of phosphate of calcium mixed with brown amorphous pigment granules (hæmatin ?), and typical though very small crystals of hæmatoidin. Quite in the centre of the concretion, and

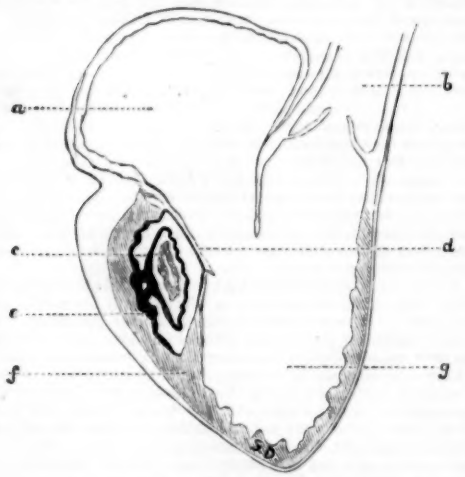


Diagram showing the relations and position of the cardiolith. *a*, Auricle. *b*, Pulmonary artery. *c*, Cardiolith supposed to be cut transversely. *d*, Right segment of tricuspid valve. *e*, Thickened endocardium (black). *f*, Papillary muscle. *g*, Right ventricle.

forming its nucleus, there was a soft material partly composed of distinct coarse fibrous filaments, mixed with much granular débris, all much softened by, or soluble in, weak hydrochloric acid. Some pigment was also found in this layer. From this structure it was evident that the concretion, as might have been expected, was nothing else than a cardiac thrombus or polypus partly calcified, adherent to the cardiac wall, and covered with endothelium. There was no other marked sign of disease or imperfection of the heart, except that there was slight thickening of the valve lying over the concretion and of the endocardium with which it came in contact; and there was an unusual number of muscular and fibrous trabeculæ in the cavity of the right ventricle. The concretion was of interest in various ways. 1. From the position of the stone it seemed evident that it could not have given rise to much trouble during life. 2. From its structure there could be little doubt that it had been growing slowly by accretion for years, and it was quite possible that it might have begun to form during fœtal life. 3. The trabeculated state of the right ventricle was an indication of some slight developmental defect, and reminded one of the spongy structure of the organ during embryonic life; such a state would of course be favourable to thrombi. 4. The deposition of endothelial layers on the surface of the thrombus gave support to the view that organisation of thrombi was due to endothelial proliferation. In this case, however, owing to the absence of the necessary elements for vascularisation, the deep layers, as they became separated from the nutrient fluid by more superficial layers, successively degenerated and became calcified. After referring to the literature of the subject, Dr. DELÉPINE said he considered the term "cardiac calculus" somewhat misleading, especially when the restrictions, which some authorities put upon the use of the term were considered. On the other hand, the word "concretion" did not necessarily convey the idea of calcification. It would seem, therefore, advantageous to apply here a terminology already in use, and to call calcified thrombi of the heart "cardioliths," in the same way as similar concretions found in the veins were called "phleboliths."—Dr. NORMAN MOORE said that a polypus of the heart was a firm clot discovered in the organ after death, and calcified polypi might be pieces of calcified substance from the valves involved in such a clot, and torn off with it at the post-mortem examination.—Dr. HADDEN asked if ante-mortem thrombus were found in the heart.—Dr. DELÉPINE replied that the fact that a layer of endothelium covered the calcified shell proved that it was not such a body as Dr. Moore had mentioned. The stone lay free from coagulum, though ante-mortem clot was found in the heart.

Mr. EDGAR WILLETT showed a case of Rupture of the Spleen which occurred in a female aged thirty-nine, who died on the third day after a street accident. At the necropsy there was hæmorrhage into the peritoneal cavity; the spleen was torn for over two inches on its outer surface near the upper margin; the right lobe of the liver was also bruised and slightly torn. The rupture in the spleen was closed by firmly adherent clot. Other injuries were present, the third to the eighth right ribs were fractured, the apex of the right lung was torn, and blood was found in the right pleura. There was no bruising of the skin visible before or after death.—Dr. DICKINSON observed that he had seen evidence of considerable rents in the spleen which had been recovered from.

The annual meeting of the Society was then held. The Secretary, in reading the report of the Council, referred to the deaths of two honorary members, Professor Donders of Utrecht and Dr. C. J. B. Williams. Dr. Cayley, in presenting the Treasurer's report, was able to show a fairly satisfactory balance. Sir Joseph Fayrer proposed a vote of thanks to the retiring Vice-Presidents—Dr. J. Hughlings Jackson, Dr. Payne, Mr. Beck, and Mr. Henry Morris. Mr. Bowlby proposed a similar vote in favour of the retiring members of Council. A vote of thanks to Mr. Godlee, the retiring Surgical Secretary, was likewise carried unanimously.

The PRESIDENT then gave his annual address, and commenced by thanking the Society for electing him to office a second time. He then briefly reviewed the work of the Society for the past session, and referred to the excellent forthcoming volume of the Transactions. He stated that the meetings had maintained their interest in spite of the temporary disadvantages attending removal and insufficient accommodation. He hoped that the migration to the west would not cause the Society to leave its wisdom behind it, but that the future would furnish as good a record as the forty-three years of the past. The Society had concerned itself with the study of the laws of disease, which, if not eternal, were at least coeval with the human race, or even with the animal kingdom. Some of their observations might retain a value even after the language in which they were written had become obsolete, so that a person who would consult them would need to be not only an inquiring pathologist, but a curious student of old English. Finally, he said a word about the manner of the work as well as the matter, and urged members to keep as much as possible to the old custom of making verbal communications, rather than tediously reading long papers. Such short addresses, though they might be less polished, were more effective than written essays, their brevity preventing that flagging of attention so often noticed under lengthy reading.

The following card specimens were shown:—Mr. W. G. SPENCER: (1) Caries of Vertebræ in a Dog; (2) Intestinal Obstruction and Abscess in a Dog. Mr. RAYMOND JOHNSON: Sublingual Dermoid Cyst.

The officers of the Society elected for the coming year are as follows:—President: W. H. Dickinson, M.D. Vice-Presidents: James Andrew, M.D.; Sir Joseph Fayrer; P. Henry Pye-Smith, M.D.; Henry G. Sutton, M.B.; Richard Barwell; J. Neville C. Davies-Colley; F. Howard Marsh; and J. Warrington Haward. Treasurer: William Cayley, M.D. Secretaries: Samuel West, M.D., and S. G. Shattock. Council: Charles Edward Beevor, M.B.; Sidney Coupland, M.D.; F. G. Dawtrey Drewitt, M.D.; William Ewart, M.B.; Percy Kidd, M.D.; David B. Lees,

M.D.; Stephen Mackenzie, M.D.; G. Newton Pitt, M.D.; George Thin, M.D.; William Hale White, M.D.; William Anderson; Charles A. Ballance; Edgar Crookshank, M.B.; R. J. Godlee; William Hickman; Jonathan Hutchinson, jun.; George Henry Makins; Herbert William Page, M.C.; Bernard Pitts, M.B.; and A. Quarry Silcock, M.D.

HARVEIAN SOCIETY.

THURSDAY, JAN. 2ND.

DR. BUZZARD, PRESIDENT, IN THE CHAIR.

Aural Complications in Acute Specific Fevers.—DR. HILL remarked that more than 50 per cent. of the cases of chronic ear diseases commencing in early life were traceable to the aural complications of fevers. The somewhat higher percentage observed before Meyer demonstrated the importance of naso-pharyngeal obstructions were doubtless due to the fact that the exanthemata are potent exciting factors in the induction of adenoid overgrowth of the pharyngeal tonsil in those of "lymphatic temperament," and indirectly of ear lesions, and cases now rightly attributed to post-exanthematous "adenoid growths" were formerly classed amongst the direct aural complications of acute fevers. After detailing English and foreign statistics dealing with the frequency of ear symptoms in the course of scarlet fever, measles, whooping-cough, mumps, and other states, the destructive nature of these complications on the membrana tympani and ossicula, if untreated at the time, was pointed out and contrasted with the rapid recovery from perforation, discharges, and impairment of function when similar conditions were not neglected, but treated *secundum artem*. In measles, pneumonia, and pertussis, in which the inflammation spread up the Eustachian tube, the otitis could often be prevented, and nearly always arrested or limited to the non-suppurative variety by appropriate naso-pharyngeal and inflation treatment. If neglected, suppuration of the middle ear resulted from tubal obstruction and accumulation and retention of tympanic secretion; the tendency to this acute suppurative stage was more marked when the middle ear became involved in scarlet fever, small-pox, and diphtheria, and if unrelieved by immediate incision of the membrane on the onset of pain or evidence of intra-tympanic accumulations, the destructive processes above alluded to resulted, and frequently also involved the labyrinth. If on establishing proper drainage, together with frequent syringing of the meatus with antiseptic lotions and inflation by the tube, the pain was unrelieved, the application of leeches or incision for mastoid inflammation, and of Leiter's continuous cold coil for less limited pain, was recommended. The use of internal anodynes also afforded relief in some instances; but if a thorough otological examination was not made and appropriate surgical measures adopted, the mere relief of pain often lulled to false security, whilst irreparable destruction was going on in the delicate auditory organ. In cerebro-spinal fever, mumps occasionally, and in typhus, the labyrinth was usually primarily involved. Such a complication might be aggravated by such remedies as salicine or quinine, which were best avoided in acute aural disease; iodide of sodium internally, or pilocarpine hypodermically, being the most serviceable drugs. In conclusion, Dr. Hill pleaded that aural symptoms should invariably be looked for early in the course of fevers, in the same way that the thoracic and renal organs were watched. With appropriate nasal and pharyngeal treatment, otitis could often be prevented or mitigated in severity. If enlarged tonsils or adenoid growths interfered with treatment they should be removed. Whilst anodynes were indicated for pain, other treatment, including early incision of the tympanic membrane, were necessary in order to limit rapidly destructive suppurative processes in the middle ear and labyrinth.—The PRESIDENT remarked upon the extreme importance of diminishing in any way the great dangers which resulted from ear disease caused by the specific fevers. Those who met with many cases of cerebral abscess and other brain lesions from this cause would best appreciate the points of Dr. Hill's paper.—MR LENNOX BROWNE said the anodyne treatment led very often to a fool's paradise. He thought that a rise of temperature in the course of a specific fever was a guide to the diagnosis of ear trouble as of other complications. Some of the ear troubles of acute fevers were, indeed, due to pharyngeal and not primary aural trouble, but only when there was no discharge from the external meatus. When discharge was present there was always aural disease. The order of importance of the specific fevers in relation to the production of aural trouble was, in his experience, the following: scarlet fever, measles, pertussis, and mumps. Purulent catarrh was rare in diphtheria. He himself would not incise the tympanic membrane unless there was very great congestion or evidence of fluid in the ear. There was no danger of leaving a hole in the tympanic membrane after such an operation. When, however, rupture of the membrane resulted from ulceration, a permanent opening was frequently left. Unlike Dr. Hill, he had found atropine of great service in relieving aural pain. He supported Dr. Hill in his recommendation to scrape the throat free from growths even during an acute fever.—Dr. SPICER inquired as to the method of using pilocarpine. An enlargement of the pharyngeal tonsil should be treated before an acute specific fever occurred.—Dr. HILL, in reply, alluded to the difficulty of obtaining good nursing for cases of ear disease. Pilocarpine should be injected subcutaneously in the form of a 2 per cent. solution. He also thought pertussis of some importance in the production of aural trouble.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

A MEETING of the Surgical Section was held on Dec. 6th, 1889.

Compound Luxations of the Ankle-joint.—MR. CROLY read this paper, which was illustrated by three interesting cases. The first was that of a farmer whose right foot was caught in a mowing machine, causing compound dislocation of the tibia and fibula forwards on the dorsum of the foot; the tendons in front of the ankle were injured, and the entire front of the joint was laid open. Mr. Croly was telegraphed for to amputate the limb, but decided, on consultation with the father, to endeavour to save the foot. The dislocation was reduced under an anæsthetic, and the wound dressed antiseptically; free incisions were made subsequently to relieve tension, and the patient recovered with a very useful foot. The second case occurred in a coal porter of very intemperate habits in May, 1888. On the patient's admission into the City of Dublin Hospital, three inches of the lower extremity of the right tibia protruded through the soft parts; the lower end of the fibula was comminuted, and the foot forcibly everted. The patient was anæsthetised with ether, the parts washed with an antiseptic lotion, and reduction effected by flexing the limb. A large drainage-tube was passed through the joint, and antiseptic dressings applied. Jointable splints were applied in the flexed position. The limb became enormously swollen the day after the accident, and bullæ appeared. Numerous free incisions were made to relieve tension. Opiates and bromides were administered. Six months subsequently the articular end of the tibia was removed, after which the wound healed. The third case occurred in a man, aged twenty-eight, who received a compound dislocation of the tibia and fibula outwards. On his admission to the City of Dublin Hospital, reduction was effected by slightly enlarging the wound. The patient, who was of abstemious habits, made a very rapid recovery. In three months he walked up and down the ward alone, and his foot is now as useful as the other. These patients, with drawings and photographs of the dislocations at the time of their occurrence, were exhibited to the Society. The cases bear out the teaching of Sir A. Cooper, "that amputation should not be performed in compound luxations of the ankle-joint."—MR. MYLES attributed Mr. Croly's success in the cases in question to his great experience, and the care which he bestowed upon them, rather than to the particular treatment adopted. He had himself seen four cases of compound luxation of the ankle, and his experience differed from Mr. Croly's.—MR. BARTON concurred in the general rule that an attempt should be made to save the limb in these cases, and desired to learn whether the antiseptic method had been carried out with the utmost care.—MR. NEWELL mentioned a case which he was watching in the Meath Hospital, the treatment of which was precisely similar to that advocated by Mr. Croly.—MR. TOBIN asked whether Mr. Croly had found tenotomy of the tendo Achillis necessary, such being his own experience more than once.—The PRESIDENT said they

treated all such cases in Jervis-street Hospital antiseptically, and they would not dream of amputating in an ordinary case of compound luxation.—Mr. CROLY, in reply, thought injuries to the ankle-joint were not favourable to primary amputation, and therefore students should be cautioned not to rush for an amputation knife in cases of compound dislocation of the ankle. In the cases which he had described he enlarged the wound to give room for drainage, and antiseptic surgery was carried out in its integrity. Tenotomy of the tendo Achillis was not necessary. It was a suggestion by Campbell de Morgan, and was injurious, as weakening the back of the leg by taking away needful support. He was glad the President had endorsed the opinion that preservative surgery of the foot ought to be kept in view in compound dislocations.

Battey's Operation.—Mr. J. K. BARTON read a paper on this case. Mary M——, a maid-of-all-work, aged twenty-six, had suffered for a year from severe pain in the abdomen, which was greatly swollen and tympanitic. Reflex vomiting was so severe as to require nutrient enemata for six weeks. The diagnosis was "inflammatory disease in left ovary." Having failed to give relief after a protracted trial, Battey's operation was decided upon. Both ovaries and Fallopian tubes were ligatured and removed; both were hard, white, and about three times their normal size. The patient recovered from the operation without a bad symptom. In a month she was up, and in two she had left hospital, healthy, vigorous, and cheerful, to earn her own living.—Mr. O'CALLAGHAN said the operation described by Mr. Barton was not Battey's, but Mr. Lawson Tait's. Battey had simply removed the ovaries, but Tait removed the ovaries and appendages. The case seemed to him to be one of retroflexion and prolapsed ovary. As to chronic inflammation, from the history of the case there was not a symptom of it.—Dr. FREDERICK KIDD did not gather from the paper that there had been any examination per vaginam. All the pain seemed to be developed on the left side, and yet the right ovary was more affected than the left. He asked how it was that there were no subjective symptoms on the right.—Mr. MYLES asked, regarding the operation itself, if they were to assume that every young woman who suffered from hysterical symptoms was to be deprived of the power of reproducing her species. To destroy the highest physiological functions of a woman was an operation that should not be lightly undertaken.—Mr. THORNLEY STOKER said Mr. Barton had not impressed upon his mind that the case was one of such extreme gravity as would justify an operation warranted only when the condition was such that life was threatened or had become intolerable by suffering.—Dr. PATTESON regarded the diagnosis as inadequate to indicate operative procedure—the left ovary being the seat of all the symptoms, though the right proved to be more enlarged and more diseased. Microscopical appearances did not point to chronic inflammation of the ovary.—The PRESIDENT said that, the woman being in great pain, and her life in imminent danger from that pain, the operation was simply done to save her life; and under such circumstances, where the woman could not have lived, there were few hospital surgeons who would hesitate to remove both ovaries.—Mr. BARTON blamed himself to some extent for the adverse criticism in not having made clear that the patient was dying of long-continued disease. The serious character of the operation he did not at all blink, nor did he suggest or think that it should be lightly undertaken. In this case he had had the benefit of Dr. Parefoy's opinion that there was no retroflexion of the uterus. He was gratified to say that the case was more successful than some of his critics seemed to think, and the girl was now capable of performing the functions of a domestic servant.

LEICESTER MEDICAL SOCIETY.

DEC. 6TH, 1889.

DR. COOPER, PRESIDENT, IN THE CHAIR.

DR. BENNETT showed a case of Morbus Cœruleus dependent probably on patent Foramen Ovale.

Cholecystotomy and Crushing of Impacted Gall-stone in Cystic Duct.—Mr. MARRIOTT read notes of a case in which he had performed this operation. P. R——, female, aged forty-two, had had eight children. She had "inflammation of bowels" twenty years ago and severe pain in the right hypochondrium ten years ago. Four years since pain and swelling began in the epigastrium, which became very severe three weeks before her admission to the Leicester Infirmary. There was bilious vomiting, but no jaundice was noticed. The urine was high-coloured; the stools were never white. On admission there was fulness over the liver, and below it a pear-shaped swelling to the right of the rectus muscle. On Aug. 27th, 1889, an incision three inches and a half long was made over the most prominent part of the tumour. The gall-bladder was seen in the wound, and the fluid, which was clear and limpid, was withdrawn by an aspirator, and the gall-bladder then opened. A loose gall-stone was removed, but another was felt firmly impacted in the cystic duct. Fruitless efforts were made to dislodge or break up the stone, and the patient was sent back to bed. The gall-bladder was stitched to the skin. Three days afterwards Mr. Marriott again operated. He enlarged the original incision to one inch below the umbilicus, and made his way to the outside of the cystic duct, when the stone could be felt. He tried to split it with a needle thrust through the duct, but failed. He then seized the stone with a pair of forceps having its blades guarded with indiarubber, and using both hands with much force, succeeded in crushing the stone and removing the fragments. The abdominal wound was then stitched up, and a drainage-tube left in the gall-bladder. The temperature was 100° on the night of the operation, and did not rise higher; the wound healed rapidly, and the patient said she felt well. The stone and crushed fragments were shown to the Society.

Cholecystotomy—Mr. BOND related a case in which he had opened and drained the gall-bladder in March, 1889, for urgent symptoms owing to obstruction in the common duct. A biliary fistula resulted, and although from twenty to forty ounces of bile were discharged daily, the patient continued in good health and gained in weight. As the fistula did not close, a second exploratory operation was undertaken in November, to ascertain the condition of the common duct. No calculus was detected. As a result of this operation, bile began to flow into the duodenum more freely, and a month afterwards only from half an ounce to one ounce of bile in twenty-four hours escaped through the fistula. It was suggested that some stretching of the duct or rupture of adhesions had been the cause of the relief.—Dr. PRATT had estimated the urea passed by Mr. Bond's patient, and found that when a small quantity of bile issued from the fistula the urine was of lighter colour than when a large quantity of bile was discharged, but that the amount of urea was unaffected by the biliary flow.—Dr. TOMKINS suggested, in explanation of the colour, that probably the total amount of urine was less when the escape of bile was greatest.

Vital Force.—Dr. BENNETT in this paper pointed out the tendency which there had always been to account for the mysterious by the supernatural, a method which yielded everywhere before the steady advance of science. He thought that life must in the same way cease to be regarded as the action of an external principle on matter, and be regarded as the outcome of ordinary processes of nature, only in peculiar form. He showed that the processes which occur in living organisms are processes of which we gain fuller knowledge day by day, and which are always identical with other chemical changes. He maintained that vital processes were governed by ordinary chemical laws, which alone were sufficient to account for the complexity of life.—Dr. PRATT maintained that living bodies possessed some principle or force over and above those possessed by non-living bodies: such as adaptability to change of environment; growth; reproduction, sexual and otherwise; repair of injury; also the impossibility of artificially producing living matter.—Several other members spoke.

THE DEVONSHIRE HOSPITAL AND BUXTON BATH CHARITY.—The annual report for 1889, just circulated, demonstrates the continued satisfactory utility of the institution. The medical statistics for the past year illustrate the remedial value of the Buxton mineral water, more especially in the relief of most cases of rheumatism, arthritic or gouty in character. Of the 2431 cases under treatment in the hospital, 359 were complicated with some form or degree of rheumatic heart complication. The report shows how far the hospital is removed from being a mere convalescent institution, and the efficiency of the work done by the medical staff.

Reviews and Notices of Books.

The Diagnosis and Treatment of Extra-uterine Pregnancy. By JOHN STRAHAN, M.D. Philadelphia: P. Blakiston. 1889.

THIS book is the Jenks' Prize Essay of the College of Physicians of Philadelphia. It divides the subject into two parts—Diagnosis and Treatment. It displays considerable research, and is a valuable contribution to this somewhat burning subject. The book seems to us to be an amplification of Mr. Lawson Tait's recent lectures, so closely does the author follow his conclusions and reproduce his comments. This being the case, we must refer our readers to our recent review of the work of Mr. Tait, and shall only indicate criticisms which will be found more fully in that review, in Mr. Tait's reply to the review, and in our reviewer's rejoinder to his reply. There can be no doubt, however, that the modern improvement of abdominal surgery has revolutionised this subject, like many others, and that comparatively recent conclusions as to treatment are out of date; we are also quite ready to give to the boldness of operators like Mr. Tait a fair share of the credit of this progress, and to take signs of impatience of criticism and disparagement of the work of others as evidence merely of youthful enthusiasm. Even after discounting all this, we still think that boldness will save many lives in the future which not timidity so much as knowledge and a sense of responsibility (the state of abdominal surgery being considered) allowed to perish in the past. A few statements have been, in our opinion, too readily accepted by the author; for instance, (p. 4) that "in extra-uterine cases the placenta can migrate, change its ground, spread here and there from its original attachment, or may even be detached altogether, and take root again." This seems to us still unproved. On page 10 we read that Dr. Rasch claims to be able to detect by bimanual examination "the smallest quantity of liquor amnii just as easily as a few drops of pus can be detected in a subcutaneous abscess." This is a most astounding statement, and, as far as we know, entirely unconfirmed. Yet Dr. Strahan proposes to erect the absence of this sign in extra-uterine gestation into evidence of the emptiness of the uterus, "as a substitute for the use of the sound," and deductions from this assertion crop up throughout the work. On page 12 the well known frequency of previous sterility (especially acquired sterility) in cases of extra-uterine gestation is said to "strongly confirm Tait's idea that extra-uterine pregnancy is caused by whatever removes the ciliated epithelium from the Fallopian tubes"—not more, in our opinion, than it confirms the view that the sterility is generally due to adhesions which take time to melt away. On page 13 we read: "The cervix uteri becomes softened and shortened, just as in normal cases, but these changes do not proceed so far." Before saying anything, we should like to know exactly what the author means by shortening, but if he means shortening of the vaginal portion, we believe that both shortening and softening are usually absent. On page 24, however, we read: "Tait is, doubtless, too confident in his own unique experience, and too sceptical as to the assertions of others. We must remember that, after all, he has only seen seventy-nine cases, ... and this number is far too small to permit of any dogmatism as to what can and what cannot happen in other cases." Then follow some very sensible remarks on the powers of diagnosis claimed respectively by surgeons and electricians. "It seems to me rather suspicious that those most famed for abdominal operations should, as a rule, express most doubt about the diagnosis of extra-uterine gestation prior to rupture, while those who go in for electricity, puncture, injections of morphia, &c., should profess to make the diagnosis offhand." The author very wisely refuses to accept cases in which the extra-uterine fœtus has passed into the uterus under the influence of electricity, and then *per vias naturales*, as anything but instances of faulty diagnosis and the induction of abortion. As regards "abdominal" pregnancy, Dr. Strahan states that Jessop's case is the only reliable one on record (p. 44); but he subsequently quotes (p. 100) a case reported by Dr. Champneys. The statement requires revision, and seems to be copied from Mr. Lawson Tait (p. 59, *conf.* p. 97). The author agrees with Mr. Lawson Tait that all such cases are secondary. That may be so, but it is not yet proven. We are not acquainted with cases in which the child "has been known to be alive *several months* after full time." No authority is given in the text for this remarkable statement.

In Part I., which deals with Diagnosis, we should have liked some definite summing up of the question, "What is evidence sufficient for certain diagnosis—what for treatment?" Before answering the question, a maxim, the author of which we cannot remember, may be quoted, for it is highly important. It is that the difficulties of diagnosis of extra-uterine gestation differ in the early and the late months. In the early months the difficulty is the "pregnancy," in the later months its "extra-uterine" character. Absolute diagnosis is, in the early months, or rather weeks, generally impossible. Practical diagnosis may be constituted by suspicion followed by symptoms of rupture; but, even before rupture, it is often not very obscure, and consists of cessation of regular menstruation, followed by more or less irregular bleeding; the presence of a globular tumour, usually in one or other posterior quarter of the pelvis; and the passage of a decidua; the last—the passage of an empty and complete decidua,—if properly confirmed, being absolutely diagnostic of pregnancy in some other part than the uterus from which it has been discharged—i. e., pregnancy either extra-uterine or in one half of a double uterus.

In Part II. Dr. Strahan speaks more strongly than the facts, in our opinion, warrant. On p. 70 he says: "In this accident [hæmorrhage after rupture], if in any, there is certain death." Such a statement is contrary to the experience of everyone who has had much personally to do with these cases, survival and recovery being by no means so rare as the author states. This erroneous statement underlies the whole question of treatment, and it of course underlies the statement that (p. 71): "Tait has operated on forty-two cases, and saved forty lives as good as lost." We must refer our readers to the review of Mr. Tait's book for the reasons why we cannot accept his figures or the arithmetical calculations deduced from them. On p. 101 personal remarks occur which are out of place in a treatise professedly scientific. On p. 113 the hitherto accepted treatment of the placenta is criticised. This has been formulated as the leaving of the placenta *in situ*, and bringing the cord out through the wound. This Mr. Tait proposes to alter by cutting off the cord short and closing the wound entirely. This operation has never, we believe, been performed, and we await its appearance and results with great interest. In the meanwhile, Mr. Tait (p. 98) and Dr. Strahan (p. 113) in almost the same language quote the case of abdominal gestation already alluded to (Dr. Champneys' case) as an illustration of the danger of the hitherto accepted method. The criticism is to the effect that antiseptic dressings were trusted to prevent decomposition, but that the open channel along the cord allowed it, the result being decomposition of the placenta. In our opinion this view is untenable, inasmuch as the temperature was normal for thirty-three days before any symptoms from the placenta began (Obstetrical Transactions for 1887, p. 462), the wound was firmly healed, and the patient was apparently quite well. The author's view was that the placenta was

infected from the intestines, on which it was planted (Obstetrical Transactions p. 471). If this is correct, to cut off the cord and close the wound would not have helped at all; but would, on the contrary, have exposed the patient to unnecessary danger in case of the usually rapid decomposition of the placenta. We shall, as we have already said, watch with much interest the record of cases treated by cutting off the cord and closing the wound. The occasional infection of the placenta, fœtal sac, &c., before any opening of the abdomen, is well known. Dr. Strahan asks (p. 115): "Can the retention of the mass [of the placenta] be more injurious to the patient than that of a full-grown fœtus?" We answer decidedly, Yes. On page 117 there is obviously a slip—easily corrected. It is said: "The best surgeons don't attempt to remove the *fœtus*"—it should be "*placenta*." Lastly (p. 122) the author minimises the dangers of the insertion of the placenta on the abdominal wall. We can only say that we know of no one who, encountering a placenta fairly planted along his abdominal incision, has ever succeeded in stopping the bleeding. The merits of the essay consist in the work which the author has obviously expended on it; its defects are want of proper scepticism and want of logic. The plan of the book is good, and its faults are quite capable of correction in a reissue.

The Physiology of the Domestic Animals. By ROBERT MEADE SMITH, A.M., M.D., with upwards of 400 Illustrations. Philadelphia and London: F. A. Davis. 1889.

THE present treatise is, we believe, the only work in the English language which contains a full account of what may be termed the comparative physiology of the domestic animals, and was therefore much needed. The French student has access to the splendid work of Milne Edwards, which unites German bibliographical knowledge with French clearness of expression, but which is of far wider scope, and to the excellent but more restricted physiology of Colin, the Professor of Physiology at Alfort; whilst the German student can consult the volumes of Gurlt, Schmidt-Mulheim, Thanhoffer, and others that are entirely devoted to the domestic animals. The general arrangement of the present work resembles that of ordinary works on human physiology, the first part dealing with the Cell, its Form, Action, and Mode of Development; and then follow in succession chapters on Food and Digestion, Circulation, Respiration, Secretion, Nutrition, Animal Heat, Muscle and Nerve, and Reproduction. It would be well if the student of human anatomy and physiology would condescend to read such a treatise as this carefully through, for it contains much interesting information which bears directly on the functions of the several organs in man. The weakest part of the work is that which deals with the reproductive functions, which, perhaps, the author thinks is a subject of minor importance for the veterinary student, whilst to give it satisfactorily would occupy too much space. Still, the space afforded by twenty pages does seem rather limited for the discussion of the whole subject. It is right, however, to say that karyokinesis and the characters of the spermatozoa are given in the first chapter. The best chapters are those in which the nutritive functions and nutrition are considered. These are really good, and the description is supplemented by admirable woodcuts, some of which are coloured.

The observations on foods are of much interest. The author, after pointing out that vegetable differ from animal foods in their nutritive principles being less concentrated, and especially in their non-nitrogenous principles being abundant, remarks that they are less digestible, owing to the cellulose which accompanies them, a material that offers great resistance to the action of the gastric and other juices, and necessitates a process of softening and comminution. Hence the excreta are more abundant in herbivora than in carnivora. The constituents of food are then discussed, and the great difference between green fodder and dry fodder is shown. The changes in composition of fodder at different seasons of the year is interestingly given, and is a point to which no attention is paid in human physiology and dietetics. The composition of the various cereals, from which their food value can easily be deduced, is minutely given. Oat straw is the most nutritious of the cereal straws. Immense differences exist in the weights of oats per bushel; the heaviest American oats examined by Mr. Richardson were found in specimens from Colorado and Dakota, weighing 48·8 lb. and 48·6 lb.; the lightest were from Alabama and Florida, and were 24·7 lb. and 26·9 lb. respectively. This must mean a great deal in an economic point of view.

In regard to ensilage, the author says: The preservation of grain by stowing it in close chambers is a very ancient one. As at present carried out, it is performed simply by placing green fodder crops, such as grass, clover, vetches, &c., in an air-tight chamber of almost any construction, and after treading the mass down covering it with boards on which pressure is exerted, either by dead weights or mechanical means. The grass may be chopped if thought desirable, and salt may also be added. It is greedily consumed by cattle. Mr. Smetham has carefully studied the changes that occur, and finds that they consist of fermentations of various kinds, with the formation of a little alcohol, with acetic, butyric, lactic, and other acids in quantity insufficient to render the silage unfit for food. By allowing the temperature to rise above 125° F. the ferments are destroyed and the production of organic acids thus largely prevented, and a sweet silage is produced. Ensilage is invaluable for preserving second crops. Experiments have proved that solipedes should receive daily 2 per cent. of their body weight in solids, and ruminants 2½ per cent. of their weight. Good hay is taken as the type of a food for the larger herbivora, and is found to show a nutrition proportion of 1 part of nitrogenous matter to 4·8 parts of non-nitrogenous constituents, cellulose being disregarded. Valuable tables are given showing the percentage of digestibility of the albuminoids, from which it appears that bean meal stands the highest, linseed meal prepared by the old process next, pea meal but little less, while the mixed hay of rather inferior quality, but similar to much hay-feed, stands lowest. Good tables are given showing the quantity of food required at different ages by cattle, horses, sheep, and swine, both when at rest and when working. At the end of the book are six plates, taken from the now well-known photographic drawings of Mr. Muybridge, showing the several phases of each action of the horse. We can cordially recommend the work to all who are interested in animal physiology.

Hygiene of the Nursery. By LOUIS STARR, M.D., Clinical Professor of Diseases of Children in the Hospital of the University of Pennsylvania; Physician to the Children's Hospital, Philadelphia, &c. Second Edition, with 25 Illustrations. London: H. K. Lewis, Gower-street, W.C.

A Manual of Home Nursing. By LOUISA EMILY DOBRÉE. London: Swan Sonnenschein & Co.

Recollections of a Nurse. By E. D. ("Sister Emma"). London: Macmillan & Co.

DR. STARR has in his little book indicated a series of hygienic rules which, if followed in nurseries, will conduce greatly to the improved health of the children who inhabit them. The rapidity with which a second edition has been called for speaks strongly for the reception which it has had, the first edition having been issued only nine months previously. It is well stated in the preface, as a reason for omitting detail with regard to drugs and methods of medical

treatment, that years of training and experience are necessary to acquire the ability to put the full value upon symptoms and to handle the tools of medicine. The first chapter deals with the features of health, and instructions are given to mothers as to the way in which they may expect the onset of disease by a deviation of those features from the normal standard for the different ages; an account is first given of the healthy functions, and then follow examples of the variations likely to be met with; these are dealt with in fifteen sections. The second chapter is devoted to a description of the nursery, its situation, size, lighting, furnishing, heating, ventilation, and cleaning. The third deals with the duties of the nursemaid, some useful hints being given with regard to her selection. The following chapters are occupied with the consideration of the child's clothing, exercise and amusement, sleep, bathing, and food. In the ninth chapter the dietary is considered; milk mixtures, peptonisation and the preparation of special dishes of service in health or in sickness are described. The last chapter contains useful directions how to proceed in case of emergency, the accidents and disorders occurring at birth or soon after, and then the accidents and disorders occurring in infancy and childhood; and under the latter heading the author gives a tabular view of the more important infectious fevers, with the duration of the disease, date of appearance of eruption, period of infection, &c., at the end describing some of the more important dressings in domestic use. The book contains much information of great value to those entrusted with the nursing of children; and although inclined to be technical in parts, there are few mothers or even trained nurses who would not gain much valuable knowledge from a perusal of it. The teaching is sound, and evidently that of a practical physician.

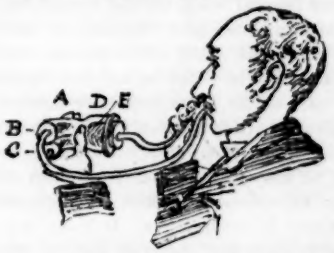
The little manual of Home Nursing is intended for the perusal of those who, interested in nursing, are not only untrained in any of its departments, but who are also wanting, it is presumed, in the main ideas on the subject. The writer has placed a high standard before her readers, but one to which they may attain to a large extent by means of perseverance and patience. The suggestions made in the manual on various departments of home nursing are good, and cannot fail, if followed, to increase the comfort of many a patient, and render lighter the task of the medical attendant. We do not mean that the suggestions are new, but that the way in which they are advanced is one which will bring them under the notice of a large number of women. Miss Dobrée is more at home in writing of the duties appertaining to the nurse than she is when considering medical terms and diagnosis, which ought not to find a place in a book of this description. One or two of the chapters are too much condensed; for instance, Chapter V. contains burns and scalds, baths of various kinds, bandaging, poultices, fomentations, application of leeches, ice, enemata, the giving of medicines, the making of various cooling drinks, medical weights, thermometers, and the contents of the domestic medicine chest, within its twenty-six pages.

Under the title of "Recollections of a Nurse" we have an account of the life of a nurse amid varying circumstances and climates, in civil life and in war time, between the years 1875 and 1885. The periods of chief interest and which occupy most of the narrative are those which were spent in Zanzibar with the University Mission, with the troops during the Zulu war in South Africa, as a member of the Stafford House Nursing Staff, and in Egypt, where "Sister Emma" was sent at short notice by the National Aid Society. The story which she tells of this portion of her life during the various surroundings amongst which it was spent is one possessing much that will interest the reader. This narrative is almost entirely a personal one, but loses nothing for that reason; whilst from time to time practical suggestions are made which are worthy of attention. When sent to Egypt by the National Aid Society, she went as "cooking sister," and was most welcome, distributing the stores placed at her command to the best advantage under medical supervision, and in the state most grateful to the sick or invalid soldiers, many of whom probably owe their life to her. Thoroughly in earnest and fond of her work, she has written in a modest manner; and the result is that the recollections are pleasant reading.

New Inventions.

A NEW INSTRUMENT FOR AMMONIUM CHLORIDE AND OTHER VAPOURS.

IN all the inhalers with which I am acquainted the fumes are generated by drawing them through the mouth and exhaling them through the nose. For the fumes to reach the middle ear, the easiest method in most cases is by Valsalva's plan. The above instrument acts perfectly, all that is necessary being to insert the nasal rubber end into one nostril, and gently blow through the mouthpiece. The fumes will then be generated, and enter the one nostril

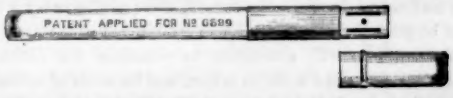


and return by the other. For the fumes to enter perfectly into the Eustachian tubes and middle ear, the patient must be told to intermittently close the open nostril, when the fumes will be felt in the middle ear. By taking away the ammonium chloride sponges, any other vapours may equally well be used by dropping the medicines on the sponge in enlarged part D. The air inhaled, coming from the warm lung, is far preferable to the cold external atmosphere. Messrs. Mayer and Meltzer, 71, Great Portland-street, W., have made the above [entirely to my satisfaction, and can supply the same.

FRED. A. A. SMITH, M.D., &c.,
Surgeon, Cheltenham Eye, Ear, and Throat Infirmary.

NEW CLINICAL THERMOMETER CASE.

MINOR IMPROVEMENTS in even the most simple of appliances are not to be despised, and the construction of an improved clinical thermometer case which is directed to diminish the chance of breakage of this necessary instrument deserves recognition by those who use it. Mr. G. Denton, of Hatton-garden, has invented a case of which the



cap is securely held by means of a spring catch, which obviates the liability to a sudden jerk in removing the cap, or to the latter becoming loose, which are recognised drawbacks to the ordinary sliding cap. The device is simple, but fully answers its purpose.

THE LANCET.

LONDON: SATURDAY, JANUARY 11, 1890.

Last week, in commenting upon some cases of influenza reference was made to the extreme probability of a speedy spread of the epidemic in London; and already the accounts leave little doubt that such an epidemic is widening its grasp with its accustomed marvellous rapidity. From every branch of medical work reports arrive of a sudden increase of sickness. The out-patient departments of the hospitals show a very large accession of new patients, and although many of these appear to be characterised by the prevailing feeling of disquietude, there is still a large proportion in whom the symptoms conform to the type of the true epidemic.

We publish this week details from private practice as well as from hospital work, but the unpublished and unwritten statements from those who have to deal with large city firms, banks, and public offices are also very striking. Numbers are away invalided or are now returning with gruesome tales of the pains they have suffered, and are performing their work in a listless fashion demanding sympathy rather than blame. It is more than probable that the dread of the epidemic, which has been fostered so largely by sensational telegrams, is responsible for a certain amount of exaggeration. It is so very easy for the public to study half lights of medical technicalities until strained expectant attention recognises the existence of the non-existent; but when all allowance has been made for this form of eccentricity, and for the additional possibility of certain *employés* seizing the opportunity as affording an excuse for remaining from work, there is still the large margin of cases to be accounted for in which the sudden onset, the severity of the frontal headache, the racking pains in the lumbar region, the tenderness over the spleen, and the subsequent prostration afford means of differentiating the affection from any of the mere common colds and catarrhs which are ordinarily rife at this season. The numbers crowding to the hospitals and dispensaries form sufficient answer to the suggestion that the whole epidemic has been "started by telegraph." Fear exists, but it takes something more real than fear to keep away from their employment workmen who are paid by piece work. The existence of the epidemic is a fact upon which no sufferer has any doubt, and the mode of meeting it demands attention. So far as the medical profession is concerned, there will be many who will be glad of the opportunity of studying it with watchful zeal, and who will endeavour to elucidate the difficult questions connected with its origin, and its mode of spread. There is no probability of the epidemic passing unutilised by those who earnestly desire to probe its mysteries. The request for information from the Local Government Board sufficiently shows the interest taken in the epidemic from the scientific side. On the part of the public, however, there is a twofold tendency which requires care; one large section, who pride themselves upon being always up to date, already shows signs of undue timidity and anxiety. They are so fully alive to the prospects of the spread of this ailment that they have almost passed into a state of panic where, after all, no panic is warranted. It cannot be too often repeated that the trouble in itself should not be regarded with morbid dread. With few exceptions the cases we record show that the fever has not been very high in this country, and that the duration has been upon the whole shorter than it has been abroad. In spite of the accounts of the deaths which have occurred, it will have been seen from the note furnished last week by our Paris correspondent that only one death had then been there registered assolely attributable to influenza. The record which has found its way into the daily press seems to be confusing and misleading. Danger lies rather in the subsequent complications than in the original malady, and thus it compares perhaps more nearly with measles than with scarlet fever or typhoid. The due recognition of this fact should minimise much of the present widespread gloomy foreboding. On the other hand, there is a growing tendency amongst the better educated to regard the epidemic as something almost too trivial for serious consideration, and this idea is often pushed to the extreme of thinking that it can be treated disdainfully by homely remedies, and by sufficient energy of self-control. But it is one thing to deny the reason for panic and another to urge the recklessness of unconcern. While maintaining that experience shows that the malady, in its usual simplicity, conforms to rule, it is necessary also to call for extreme caution both during the attack and subsequently. No disease can be ignored which so thoroughly dislocates all business arrangements, and it has been abundantly shown that, when at its height, influenza incapacitates for work of all kinds. No disease can be regarded as trivial which may be followed by pneumonia, and although it has been demonstrated that in its origin influenza does not depend upon cold, it has also been proved that it leaves in its train a special liability to pulmonary affections. These tendencies not only influence the point of view, but they may also seriously affect the choice of the method of treatment. Already there have been signs of the injudicious employment of enormous doses of antipyrin and quinine. The disease once recognised, or supposed to be recognised, the drugs which have been most mentioned in the reports from abroad have been used with a boldness characteristic of lack of appreciation of their dosage and therapeutic and toxic powers. The lines originally laid down by Dr. Peacock do not appear to have been very materially modified by anything that has since been written, and they resolved themselves mainly into directions for symptomatic treatment. He recommended for the simple form the use of diaphoretics, anodynes, stimulants, and tonics; and although the list of remedies falling into these groups has of late years been largely increased, the main principles remain the same. Antipyrin may be given to diminish the headache, but it will be more serviceable if used concurrently with salines and diaphoretics than if trusted single-handed. Salicine may be used in accordance with Dr. Maclagan's suggestion, as giving relief from pain and

fever as effectually as in acute rheumatism; and there is obviously something to be said for its prophylactic value, and the reasons which might lead to its employment rather than that of salicylate of soda. Quinine has been recommended to reduce temperature, but its chief value will be found during the convalescent stage, when the loss of appetite and general weakness emphatically call for tonic remedies. The lesson which is to be learnt from the experience of those who have dealt with large numbers abroad is essentially one of the intelligent employment of all the resources at our command for the treatment of the different urgent symptoms as they arise. There is no specific treatment which can be adopted as a matter of routine in all cases. Sometimes pulmonary symptoms predominate, in other cases gastro-intestinal troubles appear to form the main feature; and in both there may be frequent complaint of racking pains in the head or in the limbs. All these symptoms, however, are so commonly met with in other affections that every practitioner of experience is already fully prepared to cope with them. Interesting as the malady undoubtedly will be to all the profession, the interest lies in its etiology and symptomatology rather than in the search for specifics. Far more good will be effected by allaying public anxiety, and by encouraging due caution during convalescence, than by the adoption of an easy routine, which may lead to self-treatment with disastrous results.

ONE of the most remarkable characteristics of Sir JOSEPH LISTER is the persistence with which he endeavours to perfect the practical details of the great aseptic method of treatment which has revolutionised modern surgery. We are only too well acquainted with discoverers and inventors who, at their first success, stop and believe they have reached the ultimate peak of perfection. Not so Sir JOSEPH LISTER. But from the dawn of aseptic surgery, when he was using carbolic putty in his wards at Glasgow, up to to-day, his one constant aim has been to perfect the details of his treatment, and he has shown a praiseworthy readiness to give up any of his earlier dressings just so soon as he has satisfied himself that he has arrived at something better. To the unthinking it may seem strange that a "new" antiseptic dressing is so often introduced to the profession, even by the founder of the system himself. But, in truth, no better evidence of the substantial soundness of the principle upon which the system rests could be adduced, and the scientific character of the aseptic system is broadly attested by the constant perfection of its details, and by its almost daily development. Experience, therefore, forbids us to think that this last "new antiseptic dressing" is the ultimate point beyond which we shall make no advance. All we can feel about it is that in the new double cyanide of mercury and zinc (*pace* the chemists) we seem to have a stable preparation with which all suitable materials can be impregnated; that it is a trustworthy antiseptic, and when used properly is free from all irritating properties. It is impossible to read Sir JOSEPH LISTER'S account of the elaborate process of reasoning and experimentation which led to the production of the double cyanide gauze in its latest form without admiration for his remarkable persistence and scientific attainments. And those who will be at the trouble to appreciate these will be fully prepared to use the new gauze with confidence. Sir JOSEPH LISTER'S two addresses on the subject are further useful in once again demonstrating that aseptic surgery is a truly scientific system, and those who would practise it must do so with all the precision and punctilious care required in every scientific experiment. Happily the conditions are such that even a partial fulfilment of them leads to good results, and there are many surgeons obtaining from imperfect aseptic methods far better results than they could if no such precautions were taken. We hope that all such will be stimulated to aim higher, and, by a more rigid carrying out of all necessary details, secure the best measure of success that is possible.

But having said this we cannot help pointing out that there are reasons why this new gauze may not attain great popularity. In the first place, its preparation and employment are complicated, more so than is the case with the dressings now in general use. Again, its advantages over the alembroth gauze are far less striking in practice than in theory, and many surgeons are obtaining such excellent results with the alembroth dressings that they will not lightly adopt any substitute that does not come to them with more striking practical advantages than those claimed by Sir JOSEPH LISTER for his new double cyanide gauze. Another objection that may be raised against the gauze is that it is an antiseptic dressing rather than an aseptic one; and this will not commend it to those who are accustomed to use the latter. But even if it fail to take a prominent place among surgical dressings the lesson of Sir JOSEPH LISTER'S experiments and persevering research cannot be lost upon scientific surgeons.

The address to the Hunterian Society, which we published last week, has a further interest. It contains an account of operations upon two cases of old double dislocation of the shoulder, in which very gratifying results were obtained. The operation consists in doing through a wound, precisely and without unnecessary injury, just what the older methods of reduction attempt to do by force, inexactly and with serious risk of inflicting grave or even fatal damage. Sir JOSEPH LISTER specially refers to the peril in which the axillary artery is placed in the older treatment, and points out how this is obviated in his operation; but it is equally a safeguard against other dangers, such as fracture of the humerus, fracture of ribs, and even avulsion of the entire limb. Of course the success of the operation must depend upon the exclusion from the wound of septic suppuration, and thus the cases were strictly germane to the other question discussed. We are glad to notice that Sir JOSEPH LISTER has apparently decided to publish his personal results more freely than has been the case of late. While respecting the motives that have led him to refrain from doing so, we think that much good is likely to result from his later determination, and that the duty of making public all advances in medical knowledge and practice is especially incumbent upon one who is associated in the closest and most honourable way with the introduction and development of the greatest improvement in the practice of surgery that has yet been witnessed.

MORE evidence in support of the view of pernicious anæmia being a hæmolytic process, initiated probably by some ferment in the gastro-intestinal tract, and evinced, therefore, most markedly in the portal blood—a view well worked out by Dr. W. HUNTER of Cambridge, has been lately adduced by this observer in a series of papers contributed to the *Practitioner*.[1] The subject matter of his contributions consists in observations on the excretion of pathological urobilin, of blood pigment, and of iron. He made careful analyses of the urine in a typical case of the disease, and draws especial attention to the exceedingly high colour of this fluid, although the average specific gravity was never above 1016. Indeed, in the later stages, when the quantity passed was greatest and the specific gravity lowest, this deep colouration was most marked. Such a condition cannot fail to arrest attention, for it is in marked contrast to the character of the urine in other forms of anæmia. The fact, too, has been noted by other observers. Bile pigments were not the cause of the colouration, but spectroscopic examination proved the presence of pathological urobilin, which MACMUNN has shown to be distinct from the urobilin of normal healthy urine, and its occurrence was found to be associated with an excessive elimination of bile into the intestine. This increased production of bile pigments indicated an increased disintegration in the liver of hæmoglobin; but Dr. HUNTER remarks that not all the "pathological urobilin" could have had this hepatic origin, since at death, when the urine still remained of high colour, there was no excess of bile in the duodenum or small intestine. The probability is that other organs also yielded this product of blood destruction, and that some of the pigment in the urine was due to increased absorption from the intestine. Besides this, however, a study of the minute appearances of the kidney in this disease shows an accumulation of pigment granules in the epithelium of the convoluted tubules during life, whilst tube-casts and cells containing such granules may be detected, especially at certain periods of exacerbation of the disease, when it might well be inferred that the blood destruction was more intense. These facts led to an inquiry as to the excretion of iron in the urine in health and disease. Dr. HUNTER estimates that the average daily excretion of iron is from three to five milligrammes. It is remarkable that the administration of iron by the mouth very slightly, if at all, increased the amount of iron excreted. Dr. HUNTER found in one observation in health the quantity of iron excreted in the urine was 5·65 milligrammes; in one case of chlorosis, 1·71 milligrammes; in another, 1·96 milligrammes; and in a third, 1·61 milligrammes, considerably lower than the average, but consonant with the diminished richness of the blood in hæmoglobin characteristic of this affection. In a case of pernicious anæmia, however, the amount of iron in the urine passed about three weeks before death was no less than 32·26 milligrammes, twelve days later 6·52 milligrammes, and two days before death only 1·00 milligramme. It is just ten years ago that Dr. FINNY reported a case of pernicious anæmia in which Dr. EMERSON REYNOLDS found a considerable quantity of iron in the urine; but otherwise the observations on this head are comparatively few. Still, such as they are, they harmonise completely with the hæmolytic theory, and are all the more striking when it is remembered how very deficient the blood is in colouring matter during the closing stages of the disease. Dr. HUNTER thinks that these three conditions of the urinary pigments—viz., the presence of pathological urobilin, the presence of granules of blood pigment as detected by the microscopical examination of the urine, and an increased excretion of iron—are of importance not only from the pathological standpoint, but also diagnostically. Not, indeed, that such changes are always to be noted in pernicious anæmia, but in periods of its course, periods when the disease is undergoing exacerbation, and which the examination of the blood, as well as the general condition of the patient, prove to be periods of increasing hæmolysis. For pernicious anæmia is seldom—in its earlier stages at least—regularly progressive. Many physicians have had experience of cases in which there was amelioration for a time, followed by a subsequent rapid relapse of the weakness and anæmia; and the irregular pyrexia so characteristic of the affection also seems to denote this liability to exacerbation. The observations he has made regarding urobilin likewise tend to support Dr. HUNTER'S contention of the blood destruction being initiated in the portal system, and we look forward to his promised further investigations into the nature of the gastro-intestinal changes which he believes to be the *fons et origo mali*, and into the measures to be taken to combat these changes. For if his view be the true one, it is hopeless to expect any other permanently successful method of treating pernicious anæmia than by attacking the disease at its source.

[1] Observations on the Urine in Pernicious Anæmia. By William Hunter, M.D. (From the Cambridge Pathological Laboratory.)

AT the November meeting of the Society of Public Analysts, Mr. A. H. ALLEN read a paper on the possible future extension of the duties of public analysts. He urged as a grave public evil that the provisions of the Sale of Food and Drugs Act were not extended to include articles which do not come under the denomination either of a food or drug, and cited various examples of articles which in his opinion should be so included. Among them we find olive oil, disinfectants, petroleum, poisons, and mixed fabrics. The sale of poisons, including arsenical paper-hangings, fly-papers, vermin destroyers, and the like, was touched upon, and the general conclusions reached were, that all such articles should be brought under the control of the public analyst, and that the Council of the Society should draft a Bill embodying their own views and wishes. An interesting discussion followed, and was continued in the next monthly meeting. Somewhat discordant opinions were expressed, but the prevalent ideas seemed to be that some of the articles named, mixed fabrics, for example, lay quite outside the scope of the public analyst, and that it was not desirable at the present time for the Society to take action in the matter.

The question which has thus been brought before the Society is one of great difficulty as well as of great importance. We have no desire to dogmatise in regard to it, and merely offer remarks in the hope of assisting towards a satisfactory solution. There is scarcely one of the speakers at the recent debate with some of whose arguments we

cannot feel sympathy, and several of them urged points which must be admitted by all. To begin with, no one can doubt that the present law is defective in scope as well as in execution. We quite agree that the sanitary authority, which has power to deal with merely fraudulent as well as with noxious adulterations of food and drugs, might be allowed to regulate the sale of deleterious articles of dress, decoration, or household use. It does not seem desirable at present to extend this power much further. Certainly, it would not yet be wise, for example, to entrust to all local authorities an unlimited control in so delicate a trade question as is suggested by the phrase "mixed fabrics." Even with regard to the sale of poisons, it may be doubted whether a special Act, in extension of that already in force, would not be more efficient than any additional permissive powers given to sanitary authorities. But if the scope of the Food and Drugs Act is imperfect, its working is far more so, and it almost appears as though the drafting had been designed to cover the utmost possible laxity and inefficiency in execution. Local authorities may, indeed, be compelled to appoint public analysts, but they cannot be compelled to pay them properly or to find work for them. The public analyst is in too many districts little more than a name. He is elected by an ignorant and penurious board, who are quite willing that he shall do no work on the condition that he gets no pay; who know nothing of the duties of the office or the serious responsibilities which it involves, and of whom individual members are sometimes open to suspicion in regard to the very offence against which the Act is directed. If it be added that the Act, probably unintentionally, affords sanction to a scale of payment for analyses totally insufficient for good work, it will not be thought wonderful that its operation has been irregular and insufficient. Fortunately, in spite of the miserable payment allotted to them, many zealous and efficient analysts have accepted office, and many authorities, particularly those of large towns, have been active in the suppression of adulteration, so that much good has been effected, and in many places the hydra of adulteration has been scotched, if not killed. Great advances in food analysis have been made, and the Journal of the Society of Public Analysts affords ample evidence of the skill and industry of the small band of chemists by whom the real work has been done. But if many boards and many public analysts are energetic and capable, many others are inert and inefficient, and should not be entrusted with new duties. It is well to talk of State chemists. Such officers, properly appointed, well selected, armed with sufficient powers, and furnished with definite duties, would be invaluable to the State, as many individual chemists are at present; but as yet no guarantee exists that these conditions will be fulfilled in any given case, and we are therefore inclined to think that it would be better to remould the fundamental law before extending the work of public analysts.

THE subject of the best method of testing the perception of colours in railway and other officials whose actions are guided by coloured signals continues to attract considerable attention. There can be no question that it is of the highest importance for the safety of the public that the colours both of flags and of lamps should be correctly recognised by engine-drivers and signalmen at different distances, varying from a few feet to a mile or more, under every kind of atmospheric condition. The methods of testing at present practised are undoubtedly faulty and unsatisfactory in many respects. In a large number of cases the methods of testing the vision consist in the "dot and wool" tests, the former being used to determine the sharpness of vision, and consisting of a number of dots being presented within a definite area to the candidate, who is expected to state accurately their number and relative position; whilst in the wool test the candidate is directed to name the colours of certain skeins of wool that are presented to him, and to pick out corresponding skeins intermingled with a large number of skeins of other colours. These tests are used by inspectors and others entirely ignorant of the structure and functions of the eye. If the candidate answers the tests correctly, he is considered fit to undertake the duties of signalman or driver. If he fails he is rejected. It is to be observed, however, that the conditions for the recognition of colours by the candidates under these circumstances are very different from those under which they find themselves actually placed in practice, and it is not surprising that an agitation has arisen which finds expression in the resolution recently passed by the Congress of the Society of Drivers and Firemen, to the effect that the methods adopted for testing the eyesight of railway men at present in use are unpractical, and recommending that the men should be practically tried both by day and night upon the railway with actual signals at any necessary distances. They suggest also that in every case in which a member of the society is discharged or reduced on account of the failure in responding to the "dot and wool" test, such member should be carefully examined by an expert surgeon, and if he reports that the member's sight is not defective the railway company should be asked to have a practical trial with signals in the presence of the surgeons of the company and of the society. These seem to be very reasonable resolutions, and we think they should receive the support of the profession. We should hold, however, that the entire examination should in every instance be conducted by a medical expert; the interests involved are far too important to be left in the hands of a foreman or inspector, however intelligent he may be. Many points may arise having an important bearing on the question of the vision of the candidates which could only be properly appreciated by an experienced ophthalmic surgeon. It has been shown, for example, that the faculty of discriminating colour is materially deteriorated by exhaustion of the system from whatever cause it may arise. It is not surprising that failure of vision, for example, should occur in men who have been on duty sixteen, eighteen, or even, as stated at the meeting in Hyde Park in December last, twenty-three hours. Such long hours, it is true ought not to be permitted, and will soon probably be prohibited by Parliament; but whilst they are still in operation, no examination should be allowed in men whose systems must be thoroughly fatigued. Again, a man may quite innocently seriously impair his colour vision by excessive smoking, and his examination, if conducted by a medical

expert, would soon reveal the cause of the impairment of vision, and a little timely advice might prevent the loss of a situation to which he has attained by years of steady work, whilst in the hands of an unskilled inspector neither could the cause be recognised nor the remedy suggested. We see no reason why the wool test should not be used in addition to direct experiment with coloured lamps at distances varying from a few feet to a mile or more. Dr. LEDIARD, as our readers are aware from his letter in THE LANCET, has devised an apparatus which can be used in an apartment of moderate length, in which light is transmitted through red and green glasses and through apertures the size of which can be varied at the pleasure of the operator, whilst the effects of fog and mist can be imitated by neutral tinted glasses placed in front of the coloured glasses. It is obvious, however, that although such an instrument may constitute a convenient substitute for out-door work, yet that it would be more satisfactory if the candidate could be tested by distant lights on a given length of line. In this respect we are fully in accord with Mr. STRETTON. Mr. ST. CLAIR BUXTON has also brought before the notice of our readers an instrument constructed for the same purpose. Now that the question has once been raised, and its surpassing importance recognised even by the railway officials themselves, we may be sure that it will not be allowed to rest, and that in the course of a short time stringent regulations will be laid down by each railway company, by which the employment of officials with normal colour vision will be ensured.

Annotations.

"Ne quid nimis."

ARMY MEDICAL SERVICE: A NEW WARRANT.

A ROYAL WARRANT has just been issued authorising the retention on full pay of surgeons-general till the age of sixty-two, instead of sixty, should it "in any particular case be considered that the interests of the service would be materially advanced" by such retention. The committee, presided over by the Earl of Camperdown last summer, reported that their attention had been "specially directed to the public disadvantage which has arisen from surgeons-general being unable to proceed to India on duty, owing to their near approach to their age of retirement," and recommended that they should be permitted to serve until the age of sixty-two. We congratulate Mr. Stanhope upon the more judicious course he has taken in making the retention of the surgeon-general the exception instead of the rule. The new regulation will be quite sufficient to obviate the difficulty experienced by the authorities with regard to the requirements of Indian service, while it will operate in a much less degree to the disadvantage of the junior officers by retarding promotion than the course recommended by the committee. We trust, however, that he will insist upon its being clearly shown in each case that is submitted to him for his approval that the interests of the service will be thereby "materially advanced."

INFLUENZA AND ALCOHOLISM.

THAT was a strange sentence in our Paris correspondent's letter of last week which stated, from observing that those addicted to alcohol did not take influenza, the physicians had advised the use of warm alcoholic drinks. In three days no less than 1500 people were taken up for drunkenness in the streets of Paris, of whom 1200 said that they were simply following the treatment prescribed for influenza! We cannot say that there is any such exemption or advantage in this country in those who take alcohol. But the indiscriminate advice to the public to drink warm alcoholic drinks seems to us a very questionable prescription. Certainly we think that, so far, results in England will compare very favourably with those of Paris, and the preventive efficacy of warm alcoholic drinks is no part of the creed of English physicians. The great points to observe, both for preventing the disease and passing through it favourably, are to live naturally, soberly, and sensibly, to inhale fresh air, taking wholesome and simple food, and a sufficiency of sleep. If alcohol is needed in a disease with so short a pyrexia, it is in small quantity and in the stage of sweating and convalescence.

"ZOSTER ATYPICUS GANGRÆNOSUS ET HYSTERICUS."

IN the *Archiv für Dermatologie und Syphilis*, p. 561, of the 1889 volume, Kaposi relates four cases which he considers entitled to the above designation. The main features were: An eruption of vesicles and papules chiefly in groups, followed by central scabbing, and in some parts, from coalescence, comparatively large areas of gangrene being produced, and when the sloughs separated the granulating surface cicatrising often with keloid development in the scar. The eruptive stage lasted from four to eight days, and then retrogression took place. The eruption was symmetrical, did not correspond to any cranial or spinal nerves, and showed a marked tendency to recurrence, three times in the first case, and twice in the second and third after an interval of a year or two. These three cases were all in hysterical young women, but the fourth was in a male. He was only seen once, and then had scabbing vesicular groups and striæ like the third case, but on the left forearm only, and therefore, in its unilateral distribution, not quite on all fours with the other cases. Kaposi discusses the diagnosis and pathology of the affection, and considers that artificial production of the eruption may be excluded, and that it was distinctly different from the so-called spontaneous gangrene described in the case of Doutrelepont and many others, and finally refers the disease to zoster; for while, in the gangrene, bilateral distribution and tendency to recur, it differs notably from most cases of herpes zoster, each of these features may be seen occasionally in that affection. He does not, however, account for the fact of the absence of definite nerve distribution.

PHYSICAL VERSUS MENTAL DEVELOPMENT.

A CONTEST of considerable public interest has of late been carried on between the Commissioners of the Parochial Charities and the various societies interested in the preservation of open spaces in the metropolis. While the Commissioners, on the one hand, are disposed to furnish grants for the formation of libraries and polytechnic institutions, the societies consider that any large or permanent contributions towards these objects would effect no adequate good, and must divert a large sum from such purposes as their own. They point with satisfaction to the substantial voluntary aid which has resulted from the grant already made by the Commissioners towards the maintenance of open spaces, and they maintain that in view of future

requirements a further sum should be held available for the purchase of vacant land which may be threatened by the builder. They allege that libraries, at all events within the City, being little used, would instruct comparatively few persons, while the utility of polytechnics is still to some extent on trial. It will be seen that the argument thus presented in a somewhat one-sided aspect has about it an appearance of conviction. Due consideration must, however, be shown to the views of the Commissioners. As regards the formation of City libraries, this, we would say, is a measure of very dubious benefit. The bulk of the City population during the working day is too busy to read; at other hours it is distributed elsewhere. The area within which these, and probably also institutions like the polytechnics, are most required is that of the more outlying urban districts. Here there is, if anything, too little enthusiasm for such establishments. Another argument which may be urged in support of the views of the societies is that reading-rooms, lecture halls, and the like may at any time be opened if required, but open ground must be purchased while it may. For our own part, while we would deprecate the withdrawal of support from any efficient means of mental training, especially among the residents outside the City boundary, we entirely agree with those who advocate the equally important, and in some respects the prior claim, of the London oases. To city dwellers, overworked and overtired as they often are, healthy surroundings are the needful preliminaries to anything like effectual mental effort.

NIGHT MEDICAL SERVICE FOR THE POOR.

AT an inquest held in the Borough lately, before Mr. Langham, it transpired that the deceased's son had been seeking for four hours in vain for a doctor to see his widowed mother. When at last he returned home his mother was dead. This, of course, is very sad. But the public must blame itself, and not the medical profession. It is a very cheap way of relieving the mind for a juryman to say that the doctors were to blame, and would have responded to the call of a well-dressed gentleman. There is no class of the community that has a right to throw a stone at medical men for refusing service to the poor at all hours of night and day. But the time has come when the profession must insist that the public shall make provision for such service, and no longer pile it as a burden on the back of men who have been working all day, often for very inadequate remuneration. The coroner suggested that the parish should appoint a man for such night work, as is done in Paris and other foreign cities; and the jury concurred. Another plan would be to give the police power to summon and to pay a medical man for attendance in such cases.

ELECTRIC LIGHTING.

THE perils of electric lighting are constantly undergoing illustration in America, whence tidings arrive every week, and almost every day, of some new catastrophe brought about by the sudden discharge of a lighting current along an uncontemplated path. Such accidents are usually due to the unprotected state of the American wires, which being, as to a large proportion of them, laid overhead, are not only exposed to the deteriorating effects of weather, but also apt to be suddenly thrown into the way of mischief by some accident which detaches them from their supports and projects them into the streets below. When this happens, it is not surprising that men and animals which come into contact with the wire should receive serious and even dangerous shocks. The passage of a current of several hundred volts' tension through the human body is, in any case, a highly dangerous thing, and may well have fatal consequences; but if, as is usually the case with these high-tension currents, the flow of electricity is not continuous, but subject to rapid reversals, the danger is rendered still more serious; and, indeed, it must in such a case be considered a fortunate circumstance if the victim of the accident escape alive. Yet, great as is the risk which the erection of such overhead wires entails, and extensive as their use has become in New York and other American cities, it would seem that for some reason exaggerated reports have been put in circulation of the number of fatalities which have actually been recorded as due to this cause. It is now stated that the officially recorded deaths in all parts of the United States during nine years past have numbered 116. This is a sufficiently serious tale, though it does not reach the proportions which had been previously stated, and it will be sufficient to make the public here feel very suspicious of the electric current for a long time to come. That the dangers which beset its use are such only as will be eventually provided against by effectual means we do not doubt. Experience is a hard but an impressive teacher, and the problem of effectually insulating a charged electric wire and maintaining its insulation over a period indefinitely prolonged is a question chiefly of pounds, shillings, and pence. Adequate space, adequate support, adequate supervision, both in the form of inspection of the work while in progress and of continual testing when done—these are what are mainly required. The temptation to neglect them is strong, for it appeals directly to the pocket; but we hope it will hereafter prove that in the Provisional Orders which have been settled by our own Board of Trade sufficient security has been taken for the due satisfaction of these all-important requirements. The latest report from New York reminds us, however, that fallen wires or faulty insulation is not the only risk which an electric lighting installation implies. The burning of an Edison station, as is supposed, through the defective working of a dynamo is a mishap of a very different character; but then, upon the other hand, it wears a much more familiar aspect than do those accidents resulting from mere inadvertent contact with wires, and it may fairly be supposed that such accidents will not prove more seriously perplexing than the common dangers from fire to which we are only too accustomed.

DR. BACCELLI ON THE INFLUENZA IN ITALY.

FROM Rome, under date the 6th inst., we learn that the Professor of Clinical Medicine and President of the Medical Academy there, having been invited by the Royal College of Physicians of London to state his opinion on the alleged outbreak of influenza in Italy, has replied in an elaborate memoir to the effect that in Rome herself no true case of the disease has yet been admitted into hospital or reported at the Sanitary Office of the Municipality. Dr. Baccelli, however, proceeds to admit that it is extremely improbable that Rome, or indeed Italy, will be exempted from a visit of the influenza wave now making the tour of the Continent. He is persuaded, however, that when the visitation does occur it will present a decidedly attenuated character, and this on account of the higher temperature prevailing in Rome and the Italian cities as compared with that of the other populous centres of Europe. With a view to prophylaxis, Dr. Baccelli believes no other precautions are necessary than those ordinarily put in force during the prevalence of catarrhal or rheumatic affections due to cold. Since the issue of his reply, however, there has (our correspondent adds) been an undoubted visitation of the disease in more than one Italian centre. In Florence, for example, some 400 soldiers of the garrison have had genuine attacks of influenza, some so severe that the ordinary means of transport from barracks to hospital had to be replaced by the ambulance

bed. In the surgical wards, too, a gangrenous form has been rather suddenly assumed by indolent ulcers and traumatic lesions, due, it is believed, to the influenza microbe. The disease is also reported from Cesena and other towns on the Adriatic seaboard, while, notably at Spezia, it has appeared in a very characteristic, if not actually dangerous, form on the Mediterranean littoral. In all these places it seems to obey the law it has observed in the European cities where it has been most severe—to wit, a tendency to choose its victims among masses of the population living together under the same roof and the same sanitary conditions, such as garrisons, collegiate schools, and religious confraternities.

ASPHALTE OR WOOD?

A DISCUSSION has been going on in *The Times* on the relative merits of the different systems of street paving, as estimated from sanitary, humanitarian, and economical points of view. Asphalte, wood, and macadam have each found warm supporters, and each has been denounced by the others. As a result of observation for a long series of years we have come to the conclusion that the wood paving, when carefully laid on a sufficient concrete foundation, is the most desirable. The asphalte is the cause of a much greater number of accidents to horses, and these attended with serious results; and as regards sanitary objections, it does not appear to be more free from them than wood paving. The latter affords a firmer footing for horses, although by no means so firm as macadam, and if properly watered and swept appears to be as free from objection on sanitary grounds as the others. Macadam has a considerable advantage in the way of foothold, but in wet weather is very objectionable from the amount of mud; in dry weather it is more dusty than the other two, and if this is obviated by watering it is apt to degenerate into a muddy condition. Blocks of granite are perhaps less liable to objection in some respects, but they are also very slippery when dry, and the noise caused by traffic on them is very distressing. From a careful consideration of the advantages and drawbacks we are disposed to think that wood paving is the most suitable for the London streets as regards health, comfort, and humanity. The question of expense we do not touch, as we have no data on which to found an opinion.

SELF-MALTREATMENT.

THOSE persons who believe in self-treatment would do well to note the finding of a coroner's jury at an inquest lately held at St. Giles's Court. Their investigation related to the death of a gentleman of middle age, once a naval surgeon, who, relying upon his professional knowledge, insisted on diagnosing and prescribing for himself, and would have no other adviser. Believing himself to be suffering from bronchitis, he accordingly applied such remedies as he thought suitable to his condition, and felt much better. Next morning he was found in bed lifeless. A post-mortem examination revealed the presence of fatty degeneration of the heart and acute pneumonia. Death was attributed to syncope consequent on these conditions. Comment on such a case is almost superfluous. Here was an educated medical man, who, supposing he could afford to dispense with the services of a brother practitioner, acted on this supposition, who when, judging by subjective symptoms, he believed himself to be better, was really very ill, and whose sudden death, it is probable, was largely if not entirely due to an error, scarcely avoidable, in the primary matter of diagnosis. If members of the medical profession cannot better carry out a system of self-treatment, the chances of success in this work possessed by the general public must be ruinously small. The sad incident should impress on all who read it the patent fact that the first and chief essential in the work of healing is not a knowledge of drugs, but of disease. This no one can truly depend upon learning from self-examination, however careful.

DOUBLE DISLOCATION OF THE SHOULDERS.

ON the 30th ult., a man aged forty-five was admitted into the Royal Free Hospital under the care of Mr. Gant, suffering from double dislocation of the subcoracoid variety at both shoulder-joints. He had fallen, with others, from the top of an omnibus, when that vehicle was overturned, a short time before. It was the patient's impression that he, in his fall, dislocated one shoulder-joint, and that a friend fell on the other shoulder, dislocating that also. The dislocations were easily reduced. The number of these double displacements recorded is small, and nearly all are subcoracoid. They are generally produced by falling forwards from some height with the arms stretched out in front, the full force being received on the hands. Hamilton gives an example of this in the case of a coachman aged thirty-eight, who fell from a carriage. A case in which double displacement was produced by a man, aged forty-three, falling into a cellar with the arms stretched out before him is recorded by Holmes, where the displacements were produced by the sudden and violent throwing upwards of the arms in the effort to save himself. More recently attention has been drawn to this rare occurrence by the cases recorded in the last issue of THE LANCET, and in which Sir Joseph Lister operated—the one, a man aged forty-seven, whose injuries were caused by a fall from a tree; and the other, a man aged twenty-three whose humeri were displaced during an epileptic fit.

INFLUENZA AMONGST HORSES.

IN the *Veterinary Record* of Jan. 4th a brief account is given by Mr. Dollar of the symptoms and treatment of influenza which has been prevailing amongst horses in London during the last four months. A few well-marked cases occurred in August, but the disease did not prevail on a large scale till the middle of October. He found the treatment by sulphate of soda or magnesia, combined with nitrate of potash and some carminative, the most efficacious. He tried the stimulant treatment on a few horses, but with results so unfavourable that he found it necessary to discontinue it. As soon as the febrile stage has passed the administration of quinine is attended with marked benefit. Mr. Dollar points out the want of accurate information as regards "the causation, histology, or post-mortem appearances" of this disease, and suggests the collection by the Royal Veterinary College of a sufficient number of carefully recorded observations to form a solid foundation of facts on which to base a successful system of treatment, and if possible of prevention.

THE ETIOLOGY OF DIPHTHERIA.

DR. CHARLES WARRINGTON EARLE, of Chicago, has been for some time past seeking evidence as to the influence of sewage and water pollution on the prevalence and severity of diphtheria, a subject which he brought before the Ninth International Medical Congress of Washington. The conclusions at which he has arrived are as follows: Diphtheria occurs in the mountains and prairies of the great new North-west with the same malignancy as in cities; it takes place with equal virulence in vicinities remote from sewers; diphtheria once present, the inhabitants living on damp soil houses, or over cellars containing decomposing vegetables, or in proximity to manure heaps or poorly constructed sewers, seem to be subject to surroundings which increase

the severity of the malady; the contagious element seems to be carried or transported thousands of miles in a manner difficult to understand; testimony is abundant that the poison may be transported by means of cars and steamers; and, lastly, it is held that so contagious is the disease, and so persistent is the refusal to isolate the sick properly, that the only method by which it can with our present knowledge be prevented would be by the enactment of laws compelling the people to assume some responsibility in regard to contagious diseases generally.

THE PORT OF LONDON.

THE Corporation of London, as Port Sanitary Authority, have, on the advice of Dr. Collingridge, the port medical officer of health, decided to adopt within the port limits the Infectious Diseases (Notification) Act, 1889. This will secure the compulsory notification of all cases of infectious diseases occurring on board any ship, vessel, boat, as also on any barge lying within the port limits, and will thus constitute an extension of the existing requirements as to notification for the port.

INTIMATIONS TO PATIENT AND FRIENDS OF APPROACHING DEATH.

A CORRESPONDENT, referring to the absence of the Emperor of Brazil from the Empress's death-bed, reflects in severe terms on what is alleged to be the rule of the profession in Portugal, and of all the Latin races, of withholding clear intimations of approaching death till it is too late for the dying patient or his friends to express their last sentiments to each other, or for the patient to realise his position. This is a matter on which the finest moral and professional judgment is needed. We disapprove the tendency of some to add to the horrors of death by preachments of a doubtful and gloomy character. But it is right that proper intimation should be given to all concerned when the result is inevitable. It would not be right to blame the Empress's physicians without knowing more of the facts.

BACTERIOLOGY OF GRANULAR LIDS.

DR. WITTRAM of Dorpat has examined a number of cases of trachoma or granular lids occurring in the Riga Hospital from a bacteriological point of view, with the object of deciding whether the cocci which are found in this affection are or are not the cause of it. He examined thirty-six chronic and three acute cases bacteriologically, employing as nutritive media meat peptone, agar-agar, and coagulated blood serum. With the cocci thus cultivated from the contents of the follicles and secretion of the conjunctiva eight inoculations were performed on healthy human conjunctivæ, but in no case did a granular condition result. Indeed, Dr. Wittram's results tend to throw doubt on the theory that these microbes have a definite pathogenic relation to the disease in question.

CABS AND INFECTION.

IN our issue of Dec. 21st we referred to the absence of a public service of ambulance carriages for use in the conveyance of infectious cases. Since then we have been reminded by Mr. Scovell that such a service exists, and is at the disposal of the Metropolitan Asylums Board. This is true, no doubt, as is also the fact that many hospitals and parochial infirmaries are similarly provided. The number of such vehicles, however, is but limited, particularly in the case of those belonging to the board whose jurisdiction applies to the metropolis only. Moreover, they cannot always be obtained without certain preliminary formalities, and it is probable that many persons are unfamiliar with the best means of obtaining their aid in case of need. For the benefit of Londoners a broad sheet giving full instructions with regard to its own ambulances has been issued by the Asylums Board, and should be in the hands of every householder. Where any doubt exists as to the means of obtaining this valuable form of assistance application may safely be made in the first place to the local vestry. Certainly any comparison between a cab and an ambulance carriage in view of after-disinfection is altogether in favour of the latter.

PRESENTATION OF THE VICTORIA CROSS TO SURGEON JOHN CRIMMIN, L.K.Q.C.P.I., &c.

ON the 6th ult. the troops of the garrison, Poona and Kirkee, India, paraded to witness the presentation of the Victoria Cross to Surgeon John Crimmin. All the medical officers and hospital establishments not actually on duty formed up in the rear of the saluting point to await the arrival of H.R.H. the Duke of Connaught, the Commander-in-Chief, and were afterwards called up nearer his Royal Highness, who dismounted and presented Surgeon Crimmin with the badge of high distinction. He observed that he had great pleasure in carrying out Her Majesty's commands, and congratulated Surgeon Crimmin on the great honour conferred upon him, and on the great bravery and devotion to duty he had displayed in carrying out his arduous duties in the field, and exposing his life in attending the wounded under a heavy fire when serving with the 27th Beluchis at Lwekwa, Eastern Karennis. His Royal Highness hoped Surgeon Crimmin would live long to wear this coveted decoration, and to set an example in bravery and devotion to duty to all who had the honour of serving their Queen and country. After the presentation the troops marched past, the Duke taking up his position at the saluting point, and placing Surgeon Crimmin, V.C., on his right.

THE ST. PANCRAS WORKHOUSE.

THE subject of workhouse accommodation for St. Pancras is again under consideration. It is now some years since the guardians, after considerable correspondence with the Local Government Board, erected an additional building; but this does not do more than provide for the proper housing of a proportion of the inmates. A number of paupers are now located at Streatham, while others remain in the old workhouse building adjoining the Vestry Hall. The proposal is now made that the guardians shall take over the site of the Vestry Hall and rebuild the workhouse. We do not know what is meant by rebuilding, but we trust it means something more than an improvement and extension of the existing structure. With the exception of one block the old workhouse should be demolished and a new building erected upon the site. An attempt to modify the present building would not prove a success. Of this we entertain no doubt, and we trust the guardians will have the courage to see that the best use of the ratepayers' money would be the erection of a new building which will have all the advantages of the most recent thought in workhouse construction.

IDIOSYNCRASY REGARDING TANNIN.

DR. LANGE of Copenhagen mentions a case in which a patient presented a rare idiosyncrasy regarding tannin locally applied. He was a gentleman about thirty years of age, who was suffering from catarrh of the nose and pharynx, examination revealing nothing but a reddened and injected condition of the mucous membrane. The pharynx was swabbed out with a solution of tannin of the strength of 1 in 15. Immediately afterwards the mucous membrane became greatly swollen, the nostrils entirely occluded, an

irritating watery fluid being secreted. The uvula and soft palate were found to have become œdematous, the former lying on the dorsum of the tongue. Ice was given to suck and cold compresses were applied. About an hour later, the patient complained of a certain degree of stupor and of a distressing general itching affecting the whole of the surface of the body, which presented the appearance of general urticaria. The next day this had disappeared and the swelling of the nasal and pharyngeal mucous membrane had greatly diminished. The patient then mentioned that twice before he had suffered from almost exactly the same symptoms after being treated with tannin—once in the form of powder and once in that of solution. On one occasion he had been seized with severe lassitude and prostration, his "brain feeling quite empty," and he had noticed that his urine was quite dark on both occasions.

FOREIGN UNIVERSITY INTELLIGENCE.

Buda-Pesth.—Dr. Gebhard, Extraordinary Professor of Diseases of the Chest, has retired.

Cadiz.—Dr. Löhr has been appointed to the chair of Hygiene, and Dr. Gueden y Calvo to that of Clinical Surgery.

Cagliari.—Dr. R. Pugliati has been appointed to the chair of Clinical Midwifery.

Kharkoff.—Dr. Ponomareff has been appointed Extraordinary Professor of the Diseases of Children.

Königsberg.—Professor von Hippel of Giessen has been appointed to the chair of Ophthalmic Surgery in succession to Professor Jacobson.

Padua.—Professor Inverardi of Messina has been appointed to the chair of Clinical Midwifery.

Rome.—Dr. A. Mengucci has been recognised as *privat-docent* in Surgical Pathology.

St. Petersburg (Military Medico-Chirurgical Academy).—Dr. Sushchinski, Professor of Pharmacology, has resigned his chair.

Vienna.—Drs. von Frisch, Madl, and Lorenz, have been promoted to Extraordinary Professorships of Surgery.

DEATHS OF EMINENT FOREIGN MEDICAL MEN.

THE deaths of the following eminent foreign medical and scientific men are announced:—Dr. Meleux, Director of the Angers School of Medicine; Dr. Moriz Rosenthal, Professor of Diseases of the Nervous System in Vienna, at the age of fifty-five; Dr. P. Colucci Bey, formerly Vice-president of the Egyptian Medical Department; and Dr. Benedikt Schulz of Vienna.

WE understand that consequently upon the occurrence of several deaths from typhoid fever at the Royal Naval College at Portsmouth, and the notice which has been taken of the matter in the public press, the Lords of the Admiralty have appointed a special board to thoroughly inquire into the sanitary condition of the college, consisting of Captain Compton E. Domvile, R.N., A.D.C., president; Professor William R. Smith, M.D., D.Sc., F.R.S. Ed.; Fleet Surgeon R. W. Coppinger, M.D.; and Colonel H. C. Seddon, R.E.

DR. BROWN-SÉQUARD has, we learn, been a sufferer for the past three months from whooping-cough. Twice he had hoped the trouble was over, but was disappointed. We are glad to know, however, that the affection has abated considerably, and that his sojourn in Nice is likely to result in his perfect recovery.

IMPROVED FACILITIES FOR INVALID TRAVELLING BY RAIL AND SEA.

(FROM OUR SPECIAL CORRESPONDENT.)

The New Gare Maritime at Calais.—The Difficulties of Landing.—The Admiralty Pier.—The Calais Station Hotel.—The Paris Terminus Hotel.—Progress in Hotel Sanitation.—Return Journey by the Club Train.

THE statistics given in the previous articles (see THE LANCET, Dec. 14th and 21st, 1889) have shown how how great are the English interests involved in the sanitary and general condition of the town of Calais, and how much there yet remains to be done before a satisfactory result is attained. The great majority of English, however, only pass rapidly through Calais, and their acquaintance with the town hardly extends beyond the precincts of the Gare Maritime. Here, in any case, they will find very notable improvement. The old draughty wooden shanty has been replaced by a well-built stone and brick structure. Here there are numerous waiting rooms, a post office, a telegraph office, and a money exchange. The capacious buffet is well kept and warm; the attendance is prompt, the cooking thoroughly good, but the charges are very high. The steamer stops immediately opposite the station. There was a verandah between the steamer and the station, so that passengers could reach the train under cover. This has been removed. It obscured the light, and was very much in the way. Doubtless these complaints are well founded; still, I think that a verandah of some sort, a shelter against the wind, rain, and hail, would be of great service, at least to invalids. It is urged that barely twenty paces suffice to cross the quay and reach either the train or the shelter of the station; that the traveller, waiting five or ten minutes on the deck of the boat till it is his turn to land is much more exposed to the weather than during the moment it takes to walk from the boat to the train. This is true enough so far as the ordinary passenger is concerned; but the invalid does not or should not wait on deck. Those who are in charge of the patient should wait till the bulk of the passengers have landed, and promptly convey him from the cabin to the train. If, however, on reaching the quay the invalid encounters, if but for a moment, a downpour of rain, a violent gust of wind, snow, or sleet, such exposure, however brief, is not without danger, and might be altogether avoided if a covered gangway were provided. It would then be much safer to advise patients to proceed to the south even in mid-winter. Nor is it any answer to say that those who are wintering south should start in October and not return till May. Everyone has not the means of doing this, and, even with those who can afford both the money and the time, the necessity of such climatic treatment does not sometimes arise till the winter is already far advanced. I would therefore venture to express the hope that the question of a verandah from the boat to the station will again be taken into consideration, and perhaps some new method may be devised which, while avoiding the inconveniences complained about, may give the necessary shelter.

On the Admiralty Pier at Dover the train is a few yards nearer to the boat, but here the exposure to wind and weather is very great. Sometimes the waves make a clean sweep of the pier, and passengers may be drenched in stepping from the train to the boat. Nothing of the sort could happen at Calais, as the landing-stage is within the harbour and the water perfectly smooth in the roughest of weather. But at Dover there is no harbour, only a breakwater, which is not always effective, so that at times the embarking of passengers is no easy matter. Fortunately this does not often happen, the weather is not generally very bad or the tide very high just at the moment when the steamers arrive or start. Still, the Admiralty Pier is singularly devoid of shelter, and it is lucky that, being necessarily narrow, the distances from train to boat are short. Calais offers over Dover, as a still greater advantage, every accommodation that can possibly be desired immediately on landing. At the Admiralty Pier there is nothing, absolutely nothing. The passenger must enter the train, which may or may not be sufficiently warmed, he must wait till the luggage and the mails have also been placed in the train, and then the engine starts, and in a minute or two the train

reaches the town station, where there is a lavatory, and refreshments may be obtained. Not a moment, it is true, is lost; the transhipment is effected with the utmost celerity; but it is unfortunate that Dover does not possess a harbour such as would enable the ships to moor opposite the railway station and hotel.

At Calais not only does the maritime station afford all necessary accommodation, but, as there are plenty of waiters about, anything that is required can be brought direct to the train from the buffet, and this is a great advantage to those who are too ill to go about. Further, immediately above the station, and forming part of the same building, there is an excellently appointed hotel. The rooms are simply, but well furnished. Good carpets, double windows, and plenty of fires keep the place well warmed. The sea can be viewed from both sides of the hotel. The air is of the purest, the hotel being well away from the town and all its sanitary imperfections. There are also baths in the hotel, with hot water constantly ready; and the closets are built in the English style, with waste-preventer flush, and therefore they do not occasion the nuisance so generally experienced in French hotels. Here, then, immediately on descending from the train or landing from the boat, the passenger and the invalid may obtain excellent food, a warm room, a good bed—all, in fact, that is necessary to recover strength before continuing the journey, or to await till a gale has passed and a storm is over.

The same advantage will be found in London, where at Charing Cross, Victoria, and the other great railway termini there are comfortable and luxurious hotels. But in Paris this is not so. At the French Great Northern Station there is no hotel. Around, immediately outside the station, there are many hotels, but none of them of any note. A cab or carriage is indispensable, and the traveller must drive further into the town. The French Great Western line is better provided. Here a new hotel, the Terminus Hotel, was built just in time for the Paris Exhibition. From a sanitary point of view, this venture is of great interest, for I believe there is no other large hotel in Paris so perfectly drained. Unless alterations have been made very recently, many of the hotels have untrapped pipes and drain into cesspools or *tinettes filtres*. The Terminus Hotel is about the first example, in Paris, of the new principles which have now obtained in practical hygiene the sanction of the French authorities. I have carefully visited the building from roof to cellar. I could not detect a single pipe, whether for waste water, bath water, or soil which was not trapped. A two-gallon flush is provided to all the closets. The pans have no valves, so that there is nothing to get out of order, and the soil pipes run for the most part outside the walls of the hotel. To have drained in this manner is all the more creditable as the topography of the hotel did not favour the scheme. The street sewer is not laid deep, so that the hotel drain reaches the sewer at a very low level. During heavy rains or a storm the hotel outfall is below the water-mark, and the hotel drains would be flooded by the sewer. Under such circumstances, most French hotel proprietors would have remained contented with the old-fashioned cesspools, and would not have attempted to apply new methods. The enterprising owners of the hotel were not to be overcome by such difficulties, and were fully determined that in this respect the Terminus should be a model among Parisian hotels. Consequently, when the water rises in the sewer, the ordinary hotel outfall is closed, a small gas engine is set in action, and the hotel sewage is pumped up to a higher level, so as to be discharged close to the top or roof of the sewer. That, in a country like France, so much trouble should be taken and so much expense incurred for such a purpose is a most hopeful sign of the times; and the proprietors of the Terminus Hotel deserve the warmest congratulations for what must be regarded as a bold initiative on their part.

Having begun so well, it is to be hoped that they will continue the good work. In another all-important respect the Terminus Hotel as yet offers no advantage whatsoever over ordinary hotels. The ventilation is left entirely to the chapter of accidents. The dining-rooms are lofty. In the roof there are small openings that may let the vitiated air out or produce an unpleasant down draught. For the moment, however, these have been closed over by pieces of paper, so that nothing now remains but the accident of open doors or windows. Thus it happens that in a lavatory on the ground floor, the weather being cold, the windows are shut. Here the floor of the urinal, being cemented, absorbs the urine, which disengages ammoniacal gases, and these, the windows being shut, ventilate into a passage of the hotel. This could be altered with little or no expense. Perforated window panes should be introduced, and glass or other non-absorbent substance used for the floor of the urinal. Below, in the basement, I found the same fault, which will be noted everywhere in the absence of automatic ventilation—namely, that air-shafts were shut or stuffed up with towels &c. The principal kitchen, however, was remarkably sweet, and all the services were organised in a very complete and admirable manner. The worst feature in the hotel is undoubtedly the garrets where the domestics sleep. The beds are so near to one another that they recall the dormitory of a common lodging-house. Being close under the roofs, the dormitories have but sky-light windows, and these insufficient in number and dimensions. Some of the dormitories are very dark, and all are intensely cold. It is an excellent reform to so construct an hotel as to give travellers every guarantee against sewer gas, and thus protect their health; but it is also essential that the health of those who constantly wait upon travellers should be equally cared for. In this respect I must note that the servants' closets are, if anything, preferable to the masters' closets. The construction is the same, but the latter are not so well ventilated.

For travelling, the Terminus Hotel has the advantage of a booking office where tickets can be taken and luggage registered without leaving the hotel. There is a covered way leading from the hotel to the Great Western Station, and in many details new comforts and improvements have been introduced. Not least among these is the extreme cleanliness of the bedding. To better contend against the danger of epidemics, the blankets and bedding generally are frequently disinfected by heat and steam under pressure, just as if they had been used for a fever case. All these sanitary precautions and improvements will be highly appreciated by English and American travellers, though to many others they are a subject of indifference. Still, the example having once been given, it will spread, and even the most ignorant hotel proprietors will in the course of time see the necessity of following in this direction.

In conclusion, and in respect to the improved facilities of communication between London and Paris, I have but to add a few words concerning the home journey by the Club Train. This, it must be confessed, I did not effect under favourable circumstances. Starting from Paris on Christmas Eve, we were in all only twelve passengers. Nevertheless the French *train de luxe* was well warmed. In the saloon car the temperature varied from 56° to 60° F.; in the smoking saloon it was 65°; in a second saloon car, 61°; and during dinner in the dining car, 65°. To have a comfortable meal in the carriage without hurry is undoubtedly a great advantage, and gives the passenger a much better chance of escaping sea-sickness. Of course, for so few passengers, and, according to a warning given in the handbills, there was only a small boat, and the crossing was effected with some difficulty and delay. On the English side the Club Train was not nearly so well warmed, the temperature being only 52°. Worse, perhaps, than this, it was impossible to obtain any sort of refreshment. The boat being late, the train started at once, did not stop at Dover town, and it was not possible to procure even a cup of tea. After a cold sea journey, travellers, especially invalids, should be able to rely upon at least some light refreshment. Tea and soup could easily be provided in the Club Train. Thus my homeward, as my outward, journey, shows that, on the English side, there is not sufficient attention paid to the maintenance of a proper temperature in the Club Train; and though it cannot be expected that a kitchen should be provided for so short a journey as that from London to Dover, yet hot water should be always at hand, together with a little tea and other simple and portable refreshments. So important and expensive a service as that of the Club Train cannot be allowed to fail in its purpose through the neglect of such small items. They need only to be mentioned, I feel convinced, for the necessary alterations to be promptly effected; and then there will be every reason to congratulate the companies concerned on realising improvements that will be of incalculable advantage to the travelling public, and particularly to invalids.

THE HEALTH OF RUSSIA.

(FROM A CORRESPONDENT.)

IT is seldom that we are able to compare the merits of the system of *laisser aller* with those of organised individual State interference, and this for want of statistics in the former case. Most civilised Governments in matters of life and death have organised first and collected statistics afterwards. Travellers, it is true, have published interesting information on the insanitary condition and endemic disease which they have observed among communities at a low level of culture, and thus severely shaken the popular notion of the healthy savage. But it is reserved for a country which in many respects has already assimilated European ideas to present an example of elaborate statistics of public health and *laisser faire* in practice combined—a condition of things, as indicated above, of the highest scientific interest. In the near future this attitude of indifference to matters of hygiene on the part of the Russian Government will perhaps give place to a feverish activity, the appointment of innumerable officials, and the application of the accumulated experience of the West to the needs of the vast empire. The initiation of a uniform system on a grand scale, and under such varied circumstances, local, climatic, and other, will doubtless add largely to the materials for the art of comparative hygiene. For present purposes, however, I must abandon the theoretical point of view, and content myself with a cursory glance at the present sanitary condition of Russia as set forth in the last Report of 1886, just issued, and as illustrated from other current sources. I shall consider first the statistical information in its main features, and then certain general matters, matters of detail, and the evidence which in some cases must take the place of exact data.

For the more important diseases the figures show, exclusive of the army and the fleet:—

Disease.	Treated.	Died.
Small-pox	87,966	16,938
Scarlatina	96,961	18,138
Diphtheria	83,715	29,885
Measles	131,841	11,893
Catarrh	52,570	512
Whooping-cough	91,965	3,061
Typhus...	251,652	14,935
Dysentery	104,712	8,385
Phthisis	176,651	40,341
Venereal	495,758	922
Of which Syphilis	350,719	—

The evidence given by the registration of disease in Russia is no doubt untrustworthy; the very high mortality—in several governments from 40 to 50 per 1000—itself proves this. In every case the figures given by statistics must be very much below the facts, and this chiefly for two reasons: the paucity of certificated doctors, and the recourse of the people to unqualified practitioners, who, of course, make no report of their practice. There is but one civil doctor to 12,000 of the population generally, and, owing to the concentration of the profession in the great towns, the proportion for the country districts is reduced still lower. The people, in spite of resolutions of medical congresses, place great confidence in their own quacks and witch-doctors (*znákhar* and *znákharka*). The latter employ spells and herbs, with occasional orthodox remedies, such as mercury, in cases of syphilis. The witches also supply the population with poisons to put in each other's *kísha* (gruel). To return to the table given above. Epidemic small-pox in 1886 raged in all the governments (625 districts); it shows a slight falling off compared with 1881, when the number of cases was 121,937, the deaths 28,046, and the percentage 23. It appears that whole governments are without vaccine; in others, like our own Leicester, vaccination has not been resorted to for fifteen years. According to the reports from Moscow and St. Petersburg, in several cases syphilis appeared in place of the normal results of vaccination. Scarlatina occurred throughout the empire, with the exception of the territory of Semiretchinsk. Disease and mortality are on the increase: 1879, 2·8 cases in 10,000; in 1886, 10·4. Like small-pox, it affects the autumn and winter months. In the government of Elizavetpol the maximum mortality of 66·7 per cent. was reached. There exist no resources to check contagion. Linen, clothes, &c., that have been in contact with infected persons, are never subjected to disinfection even in the majority of hospitals. The only measures taken were the prohibition in one diocese to administer the sacrament to sick and healthy with one and the same spoon (*bchítza*), and a strict injunction to the rural police officers to see that there was no communication between the two classes. Diphtheria in the year 1877 was only observed in fifteen governments; to-day it prevails everywhere except in the government of Archangel and the territories of Yakút and Fergán, but the totals of sickness and mortality show a decrease compared with the beginning of the eighties:—

Years.	Cases.	Deaths.	Percentage.
1880	124,197	44,428	36
1882	109,696	37,442	34
1885	63,633	21,972	35

In some governments (Astrakhan) the mortality from diphtheria was higher than from *tchumá* (plague). The distribution of the clothes of those who died was a chief means of spreading the disease.

In the case of measles the number of persons suffering is rapidly increasing, but as the population in many localities pays no attention to the disease and the medical authorities only become acquainted with its presence when very virulent or exceptionally epidemic in its character, the returns are very incomplete. In the government of Tiflis the population even opposed medical assistance. Whooping-cough propagates epidemically almost everywhere, and from 2·4 per 10,000 in 1879 the figures attained 9·6 in 1886. Eruptive typhus rages universally, but the percentage of mortality is on the decline. The year 1881 was especially frightful, when the number of cases quadrupled. The chief causes of its spread are the overcrowding in the dwellings of the working-classes and its transport by emigrants and convict parties. The mortality rose as high as 50 per cent. in some months. Abdominal typhus in 1886 was only absent from the governments of Tiflis and Eriván. During eight years the epidemic has increased, though the mortality has diminished. It is noteworthy that in the district of Barnava (government Kostromá) the peasants themselves erected a quarantine. The chief causes are set down as pollution of the soil and throwing the sewage into the rivers. Quantities of filth in many places are heaped up on the banks of the rivers or remain for months in the courtyards of the houses. The rise of mortality in 1877 in the government of Vyátka and Moscow to 19 per cent. is attributed to the failure of the harvest; and the liability of the working-classes to the disease is no doubt largely due to bad food and insufficient clothing. Recurrent typhus shows signs of rapid growth, and has been observed in sixty-seven governments and territories. Dysentery appeared in every government and territory, and in Eriván showed a mortality of 44 per cent. The year 1886 in the amount of sickness only yielded to 1882, when there were 107,940 cases of dysentery and 14,880 deaths. This disease chiefly attacks children at the end of summer and beginning of autumn, and is traceable to the consumption of unripe fruit and vegetables, and to the use of contaminated water. The scanty use of milk and the commission of every sin against dietetics are productive of vast infant mortality among the working population. Among infants at the breast there is a disease which has received from the people the picturesque name of *gryz* (gnawing). Its symptoms are disturbance of digestion, accompanied with spasmodic pains and crying. Asiatic cholera was observed only in Vladivostók, whither it came from Japan; there were 93 cases and 56 deaths. It usually comes to Russia and thence to Europe from Persia *viâ* Resht, and may be expected to do the same this year, to judge from the latest rumours. Parotitis and erysipelas are universal, and on the rapid increase. Well worthy of attention is the dissemination of purulent inflammation of the eyes (everywhere except in the governments of Eriván and Yakút). Compared with 1885, the year under consideration shows a fourfold increase. Blindness in adults is in a majority of cases referable to the same. There has been a marked increase in the return of cases of hydrophobia, which is explained by the Medical Department as due to the opening of Pasteur stations, where persons make application who formerly escaped registration. As to syphilis, according to approximate data in 1856, those affected formed ·04 per cent. of the population of the whole empire, and 7·7 per cent. of the cases of disease under treatment in civil hospitals, but in

1876 they formed already ·06 and 11·28 per cent. In 1886 we are told that, excluding the Caucasus and territory of the Don (from which there was formerly no information), the percentage has risen from 32·5 in 10,000 to 46·8. In this year there were 31,319 new cases of contagion, among the number 21,003 women and 7096 children. The greatest number of cases occurred in the governments of Simbirsk, Smolénsk, Pskov, Samára, and Voronézh, and in Warsaw and St. Petersburg. In the country whole villages and districts are syphilised. The disease is carried from the towns by workmen returning to their villages. There the custom of eating *kásha* out of the same bowl, even with the same spoon, helps to communicate it to all. In the country there is no inspection or medical measures; in the towns the bi-weekly inspection does not touch a vast number of amateurs, and the lowest classes escape all regulations. The gigantic system of river communication, again, by its population of bargemen, towers, &c., helps effectually to spread contagion throughout the whole country. By the circular of 1878 governors are required to furnish reports every four months of the number of cases. A commission is now sitting to collect information on the real extent of syphilis, and to consider measures to meet it. Among endemic diseases the first place is occupied by malaria, of which, for all Russia, the return was 1,001,889 cases. It has increased twofold in eight years. The direct mortality is, of course, insignificant. Scrofula (*tsynga*) in seven years trebled, and is now universal, except in the government of Sedlets. A form which is frightfully prevalent, called *zolotúcha* (golden) is supposed to be a hereditary sequela of syphilis. Goitre occurs in the government of Vyátke, Kazán, Kutáis, Irkut, Minsk, Orenburg, Olónets, and in the territory of Dagestán. Is its distribution here connected with the geological nature of the soil? The population is seldom treated for it.

There is interesting evidence of leprosy. In 1886 this disease was observed already in twenty-two governments and territories. There were 346 reported cases and 29 deaths. The chief centres were the government of Astrakhan, Kurland, Lifland, and Novgorod. The information, however, is far from complete. In Estland leprosy is spread over the whole government; measures have been taken to ascertain the number of cases, but the results are so far not known. The Medical Department apparently does not hold leprosy to be contagious; the popular opinion is diametrically opposed. On the island of Ezel are mud baths. Here, according to an account published last year by a visitor with a truly horrible minuteness of detail, the same baths are used by persons suffering from this and other diseases. The fruits of such procedure are evident in the constant sporadic appearance of leprosy in the most remote parts of European Russia. The majority of persons suffering from the itch treat themselves by domestic remedies or apply to witch doctors, yet it is not without significance that the number of such persons applying for medical aid has increased from 89,801 in 1881 to 607,832 in 1886. The above-quoted statistics, with their almost uniformly crescendo character, can hardly be taken quite seriously. They indicate rather the perfecting of the machinery of registration than the actual proportions of the several diseases at different periods. However, when sanitary boards are established throughout the country, they will naturally be appealed to, when compared with the statistics of the future, as evidence of the successful warfare of hygienic science compared with the present *laisser faire*. Besides the numerical data, there is abundant material for induction in the local reports, and even in the local newspapers.

(To be continued.)

EXHIBITION OF OLD MASTERS.

THE winter exhibition of the works of old masters has now attained its majority, and after twenty years of annual collections the only sign of exhaustion is, as last year, the absence of Italian pictures. Of Rembrandt and Velazquez, the great masters of the seventeenth century, there is a strong display. No doubt in illustration of Sir Frederick Leighton's late lecture, there is a small collection of Spanish pictures, which illustrates the Spanish character, and at the same time emphasises the pre-eminence of the greatest Spaniard. The Dutch supply several masterpieces. Reynolds, Gainsborough, and Romney once more represent the strength of English portraiture and its weakness. Lord Townshend and Lord Suffolk lend two most interesting series of the Jacobean captains in Holland and great ladies of the period. In the water-colour room is a collection of the work of Alfred Stevens, the English sculptor who designed the incomplete Wellington monument stowed away in one of the side chapels of St. Paul's Cathedral.

Public Health and Poor Law.

LOCAL GOVERNMENT DEPARTMENT.

REPORTS OF MEDICAL OFFICERS OF HEALTH.

Isle of Wight Rural District.—This district is estimated to have had a population of 28,355 in 1888. The death-rate was 17·3—that is to say, larger than in some of our great towns; and, as Dr. Groves points out, the rural part of the island did not participate in the reduced rate of death which obtained generally in England and Wales, and this notwithstanding an exceptionally good climate, an absence of extreme poverty, and an area not densely populated. Amongst the insanitary conditions specifically referred to are drains close to wells, cesspits and closets unventilated, closets without water-service, drinking-water drawn from closet cisterns, damp jerry-built houses, badly smelling slop gutters, an air putrid from privies, pigsties, and slops, and the like; and these were at times found in connexion with enteric fever and diphtheria and other allied complaints. A detailed account is given by Dr. Groves of the sanitary circumstances in each parish and village in his district. Unfortunately, the story is much the same as has been told again and again in previous years; indeed, it is stated that the general sanitary state of the district at the close of the year was similar to its condition at the end of 1887. True, there has been some improvement, but it is significantly stated that this is limited to "one or two places," as at Brooke and Binstead.

Sunderland Urban District.—Sunderland has undergone a large increase in population; but notwithstanding this, Mr. A. E. Harris is able to record a distinct diminution in mortality, the rate per 1000 during 1888 having been 18·8; and the infant mortality was the lowest of all the large towns except Bristol, which generally stands well in this respect. In the same way Sunderland held a good position during the year as regards zymotic diseases, some of this result being attributed to the notification of infectious diseases, which continues to work in a very satisfactory manner. In the three years previously to notification there were 524 deaths from small-pox, scarlet fever, diphtheria, and the continued fevers. In the three years since notification the corresponding number has been 194. The Isolation Hospital did good service during the year, and amongst the 128 admissions there were 42 cases of typhus. This disease was fortunately of a mild type. To an account of general sanitary work is appended a series of tables as to meteorological and statistical matters, as also disease charts.

Huddersfield Urban District.—The year 1888 exhibited the lowest death-rate recorded by Dr. Cameron in Huddersfield—namely, one of 18·5 per 1000; but even a lower rate should be aimed at in a borough which has the largest area for its population of any of our large English towns. The zymotic rate was 1·54 per 1000, as opposed to 3·39 in 1887. After discussing the vital statistics and the incidence of disease in the district, Dr. Cameron states that he has made a report on the prevalence of lead-poisoning in the borough, but that it has been held desirable to defer its publication for some time. House inspection, supervision over milk-shops, dairies, and canal boats, have continued to occupy the attention of the sanitary department; but overcrowding needs dealing with, the town refuse should be more expeditiously disposed of, more infectious hospital accommodation is required, the population need protecting against lead-poisoning by drinking-water, the extension of domiciliary visits in infectious cases is urged, and attention is drawn to the need for purifying the sewage.

VITAL STATISTICS.

HEALTH OF ENGLISH TOWNS.

IN twenty-eight of the largest English towns 6450 births and 4889 deaths were registered during the week ending Jan. 4th. The annual rate of mortality in these towns, which had been 23·1, 23·5, and 21·8 per 1000 in the preceding three weeks, rose last week to 25·2. This marked increase in the recorded mortality was, at any rate, in part due to the fact that the previous week had included the Christmas holidays, during which there is considerable delay of registration. During the thirteen weeks of last quarter the death-rate in these towns averaged 19·4 per 1000, and was 2·1 below the mean rate in the corresponding periods of the ten years 1879–88. The lowest rates in these towns last week were 14·5 in Leicester, 16·4 in Birkenhead, 16·6 in Huddersfield, and 17·7 in Nottingham. The rates in the other towns ranged upwards to 31·1 in Bolton, 31·7 in Blackburn, 32·5 in Preston, and 32·8 in Manchester. The deaths referred to the principal zymotic diseases, which had been 413 and 373 in the preceding two weeks, rose last week to 423; they included 166 from whooping-cough, 80 from measles, 59 from diphtheria, 52 from scarlet fever, 34 from "fever" (principally enteric), 32 from diarrhœa, and not one from small-pox. No death from any of these zymotic diseases was recorded during the week in Derby or in Huddersfield, while they caused the highest death-rates in Salford, Bolton, and Plymouth. The greatest mortality from whooping-cough occurred in Plymouth, Salford, Bolton, Newcastle-upon-Tyne, Birkenhead, and Bristol; from measles in Bradford, Norwich, and Liverpool; and from scarlet fever in Blackburn and Plymouth. The mortality from "fever" showed no marked excess in any of the twenty-eight towns; and the 59 deaths from diphtheria in these towns included 32 in London, 5 in Salford, 4 in Birmingham, 2 in Plymouth, 2 in Bolton, 2 in Sheffield, and 2 in Newcastle-upon-Tyne. No death from small-pox was registered in any of the twenty-eight great towns. Only one case of this disease was under treatment at the end of the week in any of the Metropolitan Asylum Hospitals, and but 3 in the Highgate Small-pox Hospital. The number of scarlet fever patients in the Metropolitan Asylum and London Fever Hospitals at the end of the week was 1570, against 1667, 1594, and 1609 on the preceding three Saturdays; 122 cases were admitted to these hospitals during the week, against numbers declining in the preceding four weeks from 154 to 103. The deaths referred to diseases of the respiratory organs, which had been 552, 518, and 467 in the preceding three weeks, rose last week to 843, and exceeded the corrected average by 301. The causes of 101, or 2·0 per cent., of the deaths in the twenty-eight towns last week were not certified either by a registered medical practitioner or by a coroner. All the causes of death were duly certified in Bristol, Leicester, Oldham, Nottingham, and in six other smaller towns. The largest proportions of uncertified deaths were registered in Liverpool, Sheffield, Sunderland, and Halifax.

HEALTH OF SCOTCH TOWNS.

The annual rate of mortality in the eight Scotch towns, which had been 26·1 and 24·6 per 1000 in the preceding two weeks, rose again to 26·5 in the week ending Jan. 4th; this rate exceeded by 1·3 that which prevailed during the same week in the twenty-eight English large towns. The rates in the Scotch towns last week ranged from 17·7 and 18·1 in Greenock and Aberdeen, to 29·8 in Leith and 30·6 in Glasgow. The 686 deaths in the eight towns showed an increase of 56 upon the number in the previous week, and included 33 which were referred to measles, 22 to whooping-cough, 8 to diphtheria, 7 to "fever" (typhus, enteric, or ill-defined), 7 to diarrhœa, 6 to scarlet fever, and not one to small-pox; in all, 83 deaths resulted from these principal zymotic diseases, against 88 and 77 in the preceding two weeks. These 83 deaths were equal to an annual rate of 3·2 per 1000, which exceeded by 0·9 the mean rate last week from the same diseases in the twenty-eight English towns. The fatal cases of measles, which had been 26 and 25 in the preceding two weeks, rose last week to 33, of which 22 occurred in Edinburgh, and 9 in Glasgow. The 22 deaths from whooping-cough showed an increase of 5 upon the number in the previous week, and included 10 in Glasgow, 7 in Edinburgh, and 2 in Dundee. Of the 8 fatal cases of diphtheria, corresponding with the number in the previous week, 4 occurred in Edinburgh and 3 in Glasgow. The deaths from "fever" and diarrhœa, however, showed a decline; 2 deaths from "fever were returned in Glasgow and 2 in Perth. The 6 fatal cases of scarlet fever included 3 in Leith and 2 in Glasgow. The deaths referred to diseases of the respiratory organs in the eight towns, which had increased in the preceding five weeks from 121 to 189, further rose last week to 205, and exceeded the number in the corresponding week of last year by 65. The causes of 76, or more than 11 per cent., of the deaths registered in the eight towns were not certified.

HEALTH OF DUBLIN.

The death-rate in Dublin, which had been 33·9 and 24·5 per 1000 in the preceding two weeks, rose to 34·9 in the week ending Jan. 4th. During the thirteen weeks of last quarter the death-rate in the city averaged 26·6 per 1000, the mean rate during the same period being 17·8 in London and 20·7 in Edinburgh. The 236 deaths in Dublin last week showed an increase of 70 upon the number in the previous week; they included 5 which were referred to "fever," 4 to diarrhœa, 3 to measles, 3 to whooping-cough, 1 to diphtheria, and not one either to small-pox or scarlet fever. Thus the deaths from these principal zymotic diseases, which had been 19 and 11 in the previous two weeks, rose again last week to 16; they were equal to an annual rate of 2·4 per 1000, the rate from the same diseases being 2·4 in London and 6·4 in Edinburgh, in which city a severe epidemic of measles prevails. The deaths from "fever" exceeded the number in the previous week by one; and the deaths from the other zymotic diseases also showed an increase. The deaths of infants exceeded the number in the previous week, but the excess in the deaths of elderly persons was especially marked. Eight inquest cases and 6 deaths from violence were registered; and 57, or nearly a quarter, of the deaths occurred in public institutions. The causes of 23, or nearly 10 per cent., of the deaths in the city were not certified.

Correspondence.

"Audi alteram partem."

THE NEW SYDENHAM SOCIETY.

To the Editors of THE LANCET.

SIRS,—The Council of the New Sydenham Society will feel much obliged if you will allow me a brief space in the pages of THE LANCET to explain to our members and to the profession generally the somewhat peculiar position in which we find ourselves at the beginning of the new year. We have three books just ready for issue which we shall be obliged to hold back for some months unless we can make a considerable addition to last year's income. Our translators and printers are, in fact, ahead of the subscription list. We have had a prosperous year, our income having been nearly £500 more than in the previous one, and we have already issued an average number of books. What I wish now to make definitely known is that if a moderate number of new members could be immediately obtained, we could within the current month issue the second volume of Henoch "On Diseases of Children" for the current year (1889–90.) If this cannot be done, this volume, as well as the two others now ready, must wait awhile and must count in the series for 1890–91. As the volume is now in Mr. Lewis's hands, it seems to the Council a great pity that its issue should be deferred, and we confidently hope that an effort will be made by our members and others to obtain the necessary funds. Two hundred new members subscribing each for two years would secure this desirable result. The works which we have already issued for 1889 are the following:—"Charcot's Clinical Lectures on Diseases of the Nervous System," vol. iii.; "Atlas of Illustrations of Pathology," fasciculus vii. (containing urinary calculi, enlarged prostate, &c.); "Cohnheim's Lectures on General Pathology," vol. ii.; "Lexicon of Medicine and the Allied Sciences" (based on Mayne's Lexicon), by Henry Power, M.B., and Leonard W. Sedgwick, M.D., part xvi.

If, as I suggest, new members will subscribe for *two* years at once, they will obtain for 1888 (in addition to the

above for 1889) the following four: "Spiegelberg's Text-book of Midwifery," vol. ii.; "Lexicon of Medicine and the Allied Sciences," part xv. (completing vol. iii.); "Henoch's Lectures on Diseases of Children," vol. i.; "Cohnheim's Lectures on General Pathology," vol. i. Mr. Lewis, our agent, will have pleasure in giving details as to the terms on which the first volume of Spiegelberg and the previous issues of the Lexicon can be obtained separately. During the year we have printed a full list of our members and of those who act for us as local secretaries. This list can be had on application. It will be seen that in many large towns we have very few members, and that in not a few we have no local secretary. The Council will be very glad to receive the names of any who are willing to act for us in the latter capacity. Our experience is that the success of the Society depends to a very large extent upon the activity of our local secretaries.

I may just add, in conclusion, that our Lexicon of Medical Terms, the somewhat slow progress of which some years ago was regarded with discouragement by our members, is now well advanced into its fourth volume, and may be considered to be at least two-thirds complete. As to its excellence, I believe there are no two opinions.

I am, Sirs, yours &c.,

JONATHAN HUTCHINSON,
Hon. Sec., New Syd. Soc.

Jan. 6th, 1890.

THE RECONSTITUTION OF THE UNIVERSITY OF LONDON.

To the Editors of THE LANCET.

SIRS,—The scheme for the reconstitution of the University of London prepared by the Senate, as the result of the recommendations of the Royal Commission, is now before the world. It has been adopted as a basis of conference with University and King's Colleges, the Royal Colleges of Physicians and Surgeons, the Council of Legal Education, and the Incorporated Law Society. It has been sent to members of the Annual Committee, and has been the subject of criticism in your columns; it therefore behoves all those interested in the matters it concerns and in higher education generally, to read, mark, learn, and inwardly digest it. To those who, like myself, have laboured as members of the Special Committee appointed by Convocation in 1885, the removal of the confidential reserve which has hitherto sealed our lips must be especially agreeable. It is particularly desirable that Convocation, by whom, be it remembered, the movement for reform in the direction of increasing the teaching element and influence in the University was initiated in 1877, should have ample opportunity collectively and individually to consider the proposals now made by the Senate, in order to see how far such changes as would result from the scheme are likely to secure fair representation of all interests which are centred in a University, and promote that which all parties profess to hold in view—"the promotion of liberal education throughout Her Majesty's dominions." One of the few rights prized by Convocation is the power of accepting or refusing a new Charter. The Royal Commission has humbly recommended Her Majesty that before any further steps are taken, Convocation as well as the Senate (Clause 37) should have "a reasonable time" to consider the report and its suggestions. With a view to such consideration I offer the following reflections.

The final scheme of reform adopted by the Senate bears close resemblances to the first scheme of Convocation, and to that which the Senate had in hand when the Commission intervened, and it would be affectation to pretend that the same hand is not evident in them all. Eighteen out of a reconstituted Senate of thirty-eight are to be outside collegiate representatives, ten are to be nominated by the Crown, and the same number elected by Convocation. The constituent colleges are to be "in or near" London. The faculties are to be electoral bodies only, each to send up three Senators, and to appoint the bulk of the members of each Board of Studies. These latter will be influential bodies in close *rapport* with the Senate in all matters concerning teaching and examining. Lord Fry was anxious they "should not be diluted with members appointed from Convocation" (Q. 1041). Considering Convocation is to elect two out of a possible twenty-five or more, the dilution will certainly be of a remarkable character. This scheme, alas, is unique in embodying provisions for abrogating matriculation in the case of certain persons of a certain age and who conform with certain conditions, and in offering lower-grade degrees in medicine. This proposal, intended to satisfy the "medical grievance" latent in former schemes of reform, is painfully prominent in the last; it is directly opposed to the wishes of Convocation, the traditions of the University, and the repeated promises of the Chancellor and Vice-Chancellor. The Royal Commission rejecting on academic grounds the prayer of the Royal Colleges for power to confer a Doctorate, divided in opinion as to the desirability of establishing a second University in London, and having no medical representative amongst them to secure the interests of higher medical education, yielded to the loud demands of the medical schools, and called upon the University to make Doctors of licentiates. The Commissioners express the opinion that in the medical faculty alone the pass degrees of the University are based upon an honours standard; whereas the truth is that if the purely medical examination be compared with the corresponding examination in the other three faculties, it will be found that in every case the percentage of passes is highest in the medical faculty.

The report of the evidence taken before the Commission contains much that is entertaining in the shape of attacks upon the University. Some comfort is to be derived from the mutually destructive character of the criticisms of its assailants. The matriculation which Mr. Fitch's wide experience enables him to consider a good leaving-school examination, according to Sir Andrew Clark fosters cramming and encourages a "meretricious smartness." Mr. Rivington, on the other hand, thinks the matriculation requires omniscience, and the standard of the preliminary scientific is too high (Q. 1669); while Dr. Norman Moore finds it difficult to make sure that a London medical graduate knows anything! Indeed, this authority thinks there is "only one" point in which the present University is thoroughly satisfactory, and that is its name. This he would not be sorry to see taken away. (Q. 1575.) The Commission did not take him seriously, and Sir James Hannen playfully suggested (Q. 1581) that the "University of St. Bartholomew's" would not sound badly if hard pressed for a second designation. In this Dr. Moore, with becoming modesty, acquiesced. Mr. Erichsen thought the M.D. standard was far too high for the average medical student (Q. 220). Sir James Paget thought the M.B. could be passed by those who passed the conjoint examination, and "he could say the same for the M.D."; while Mr. Rivington declared that the medical examination required to be increased in severity. (Q. 1662). The President of the College of Physicians said the general course of the examination for London University degrees was to repress the study of practical medicine, and fill the mind with isolated bits of scientific knowledge. (Qs. 780 to 807.) The registrar of the same College objected very much to what the President had said in regard to the London University (Q. 888); and the President of the College of Surgeons, who has examined for most of the degree-giving bodies in the country, had no doubt that the profession owed more to the University than to any other public institution for the good it has done in the way of reform of medical and surgical education (Q. 828).

In the final scheme approved by the Senate, the preliminary scientific examination of the University is to be waived in the case of students certified by the Royal Colleges in such subjects, provided the examination held by these bodies satisfies the Senate. We know what would have satisfied the Royal Colleges in this matter, for in Clause 15 of their Draft Charter they proposed to make their licentiates M.D.s without any guarantee of any additional knowledge, and without any examination in zoology or botany. We know what would satisfy the Vice-Chancellor, for he stated that the present examinations of the Colleges would justify the conferment of M.D. upon their licentiates. (Q. 1188.) Will this satisfy Convocation and those concerned for the maintenance of medical education and examination?

Lastly, all M.B.s are to be turned into M.D.s, whether they like it or not; existing M.D.s and those who pass on the old lines are to be M.D. Lond. (Honours), though they only looked for a pass; and a new M.D. degree "not requiring so high a standard as the present examination" is to come to pass. Those acquainted with the present work of the University know well that the Intermediate M.B. and Pass M.B. are relatively stiffer examinations than the M.D., at which latter 80 per cent. pass. These

two will have to be "modified to meet the requirements of the medical schools." Could any proposal be more unjust to those who have relied upon official utterances that these things could not be? The bribe offered to M.B.s is as distasteful to them as the proposed vulgar ostentation of M.D. Lond. (Honours) is to the Doctors.

We are assured there will be no difficulty of distinguishing the future M.D. Lond. from the M.D. Lond. (Honours). Perhaps not, but the distinction will hardly be a nominal one. The Commissioners point out, as an argument against the establishment of a new University, that "if there were two Universities, both bearing the name of London (however differentiated), it would be hardly possible for some time to avoid confusion, and some encroachment by one upon the reputation of the other" (Clause 16); and Sir James Paget allowed "it would be impossible to distinguish the degree of the University of London by any appropriate title" (Q. 1223). Yet the Commission recommends (Clause 35), and the Senate approves (Scheme D), that existing M.D.s are to be put off with a distinction which will mark no difference! Many will doubtless discard the parade of a futile and fictitious distinction which they never desired or deserved. They remember, and so do Convocation and scores of undergraduates, the words of the Vice-Chancellor on Nov. 13th, 1886: "Although some schemes were afloat which rather implied that the University of London should be the great body in England for granting the degree of Doctor of Medicine, that was not likely to take place. It was bound, not only for its own sake, but in fairness to the Government and the people, to maintain always that its degrees in the future, as in the past, shall constitute distinct honours." The words of the Chancellor are more recent and not less emphatic, and were loudly cheered on Presentation Day, when he said: "There are two points upon which the opinion of the Senate and Convocation appear to me to be pretty clear—We object to lowering the high character of our degrees, and we cling to the imperial character of the University; the high character of our degrees will be maintained." Let the Chancellor and Vice-Chancellor stand by their pledges, and for my own part I believe Convocation will stand by them.

I am, Sirs, yours faithfully,

Albert-terrace, W., Jan. 6th, 1890. WILLIAM J. COLLINS.

To the Editors of THE LANCET.

SIRS,—As in a short time Convocation will be asked to express its opinion on the question of the reform of the University of London, it is very desirable that the subject should previously be fully discussed in the medical press, in order that the importance and real character of the issues which have to be determined may be realised. For fifty years past it has been the proud boast of the present University that it has not only conferred a degree in medicine the value and high character of which have been universally recognised, but also that by its example the entire standard of medical education has been raised; and yet we are now asked to sanction a scheme which will absolutely abolish all these special features and reduce the examinations to the level of those of the Scotch Universities and of the Conjoint Colleges. Either for half a century the whole policy of the University has been one gigantic mistake, or else in sacrificing its distinctive features a fatal error will be committed. Let us glance at the details of the scheme in so far as they affect the medical degrees. The matriculation is to be relegated to the constituent Colleges, in spite of the fact that in one year, according to last year's calendar, no less than 1649 persons—chiefly schoolboys and school-girls—were able to pass that terribly severe ordeal. The Preliminary Scientific is to be abolished as too severe an intellectual test, and the modicum of scientific culture required by the Conjoint Board is to be accepted in place of it. This examination has long been looked upon as a very important feature in the M.B. curriculum. It was thought that a year's training in pure science was of great value as an introduction to the more strictly professional studies. It would appear, however, that this is now considered a mistake, and that future London M.D.s will require only an exceedingly elementary knowledge of chemistry and physics, and none at all of biology. True, we have the proviso that the examination must be to the satisfaction of the Senate—a sufficient test of competent knowledge in the subjects of the said preliminary scientific examination. But the Senate is already aware of the scope of the scientific test of the Conjoint Board, and must know that it is not likely to be raised to any much higher level.

As to the future of the Intermediate M.B. and of the M.B. itself, we at present know less; but it must be futile to keep the standard for the final examinations high, whilst that of the earlier ones is reduced to a minimum. Great would soon be the outcry if the latter served as a trap to delude unfortunate victims into the study of medicine only for them to be ruthlessly rejected at the close of their student career. Apparently the purely professional examinations will also be handed over to the Conjoint Colleges, which are not likely to make any sacrifice of their own interests for the sake of the University of London. They will thus virtually acquire the power (which they have so long coveted) of being able to dispense degrees with ease, certainty, and rapidity. Such is to be the result of the agitation for *higher* medical education in London.

It seems to have been felt that this comprehensive scheme of reform was somewhat unfair to existing graduates, and accordingly, by way of compensation, they are to undergo the interesting process of being "kicked upstairs." M.B.s are to be made M.D.s, and M.D.s will become M.D.s with honours. Whether graduates will show adequate gratitude for this bountiful distribution of favours remains to be seen. Perhaps they will prefer to keep unimpaired the distinctions which they have genuinely gained, rather than to have fresh ones gratuitously thrust upon them. But the great question, after all, is whether it is really necessary thus to destroy the reputation of what has been considered a degree worth obtaining, and at the same time allow what is virtually a new university to start with that prestige which must for a time be associated with the old name? If it be such an essential matter that every London medical student should be able to obtain a degree on easy terms, then do not trade on the honourable name and traditions of the old University, but let a new degree-conferring body be established. By all means let it be so arranged as to carry on a successful downward competition with each and every other university at home or abroad, and let it become the most perfect machine in the world for turning out medical graduates; but let its history, origin, and intentions be fully known, and not disguised by the glamour of a more respected name. Then may the present University pursue without interruption its honourable career as the pioneer of medical education, and as the place to which the more ambitious and distinguished students from all parts of the empire will continue to resort in order to obtain a degree which shall still be held everywhere in honour and respect.

I am, Sirs, yours faithfully,

Bloomsbury-sq., Jan. 7th, 1890. J. WALTER CARR, M.D. Lond.

CLINICAL TEACHING ON FEVERS IN GLASGOW.

To the Editors of the THE LANCET.

SIRS,—The letter of Dr. Allan Jamieson, which I am very glad to see in your columns to-day, ought to strengthen our hands in Glasgow in overcoming the difficulties that have unexpectedly arisen in respect of the clinical teaching of fevers. I earnestly join with him in hoping that Dr. Allan, whose zeal and efficiency as the chief officer of the City of Glasgow Fever Hospital are beyond question, and whose services as a teacher are equally desired by all, will not allow himself to be influenced by any personal considerations, but will take up again and follow out to its legitimate conclusion the line he has pursued hitherto. I should like to give a brief sketch of what has been the plan actually adopted here, which necessarily differed, and must differ, somewhat from that in the Edinburgh School, owing to the distance of Belvidere Hospital from all our main centres of medical instruction. Practically this makes it almost impossible in winter to organise a visit to the hospital, except on Saturdays, and accordingly Dr. Allan's personal and more elaborated instruction has always been given in summer, when it is possible for two or three hospital visits to be arranged for in each week. But, with the entire concurrence both of Dr. Russell, the health officer for Glasgow, and of Dr. Allan, I have been for many years in the habit of informally organising parties of (say) thirty members of my own class of Practice of Medicine in the University to visit the Fever Hospital on Saturdays throughout the early

part of the winter session, there being a group told off for this purpose from week to week, so that the whole class may, if so disposed, visit in rotation; and as long as I am engaged in lecturing on febrile diseases, there is thus kept up an interest in the subject practically, and, as far as is possible, opportunities are given for witnessing at least the leading phenomena—rashes, thermometric scales, desquamation, throat and other complications—in individual cases of epidemic and febrile disease. On alternate years, when I am not so much engaged with the fevers as with the chronic constitutional diseases, a similar method has latterly been pursued by my colleague, Dr. McCall Anderson, in his clinical class; and Dr. Samson Gemmell, of the Andersonian College, has also furnished a contingent from his class; so that I have frequently had the great pleasure of meeting and sharing the duty with him of instructing our joint students, even within the last few weeks. But I believe we are all careful to explain to our pupils that this is a mere sample, as it were, of the clinical teaching of fevers, and that we look to the summer course of Dr. Allan as the completion of all our efforts for such as desire or are able to attend. At the same time, you will observe that this admittedly elementary instruction is not limited to the forty pupils who have hitherto enrolled with Dr. Allan as his maximum, but reaches, more or less completely, a much larger number. We have thus made what may fairly be called a good beginning in Glasgow (if only a beginning) in the direction now so much advocated by Dr. Glover and others; and this had its origin not in any pressure from without, but simply in the desire to develop, as far as possible, the means of practical teaching that were accessible to our students. Dr. Allan, as the official head of Belvidere Hospital, has lent himself to the movement *con amore*; and we are all, I believe, desirous that in any future extension of it he should assume more and more of the control and superintendence of the teaching, preserving at the same time his independence as a public officer. When Dr. Allan applied for the use of my class-room in 1886, it was at once granted, not as attaching him in any exclusive sense to the University, but as giving him the advantage of the only place in the West-end where he could comfortably meet the majority of those who might wish to become his pupils, and where he and they could have all the necessary means and appliances and a warm welcome besides. This informal but perfectly effective arrangement continued undisturbed down to August last. I will not enter here into the causes that since then have tended to disturb it. Your readers will easily perceive, I think, that my only desire throughout has been that the work should be done, alike for the sake of the University students and for the whole medical school. Dr. Allan's apparently sudden resolution to retire from this work was formed and announced without any consultation with me, and is universally regarded here simply as a calamity, which we are puzzled even to comprehend. We still hope and believe that his resolution may be overcome, and that he may be induced to continue, in the general interest, the admirable instruction he has hitherto given.—I am, Sirs, yours faithfully,

Glasgow, Jan. 4th, 1890. W. T. GAIRDNER.

THE INFLUENZA EPIDEMIC: A REQUEST FOR INFORMATION.

To the Editors of THE LANCET.

SIRS,—The epidemic of influenza appears at length to have reached this country, and I am engaged in collecting, for the Medical Department of the Local Government Board, information which may help to elucidate the unsettled questions relating to the etiology of this disorder. I trust to your kindness to be allowed, through your columns, to ask for the assistance of your readers towards this end. The points on which I especially wish for information are:—

1st. The dates of the earliest occurrence in their respective localities or practices of cases of influenza presenting distinctive characters (among which I may especially mention marked nervous depression, out of proportion to the gravity of the catarrhal or other local symptoms, and not unfrequently beginning suddenly), or of such as were the precursors of an extended prevalence of similar cases.

2nd. Cases illustrating the introduction of the disease by importation from elsewhere, as from abroad, from other localities, or (in the case of institutions) from outside; also cases illustrating its mode of propagation among mankind and animals, by infection or otherwise; or, on the other hand, cases in which its origin in imported infection could apparently be excluded—e.g., in ships at sea.

3rd. Cases in which the length of the period of incubation of the disease could be fixed.

I shall be greatly obliged to any of your readers who may favour me with information on any of the above points. Communications may be addressed to me as below, leaving the postage unpaid.

I have the honour to be, Sirs, your obedient servant,

H. FRANKLIN PARSONS, M.D.,
Medical Inspector.

Local Government Board, Whitehall, S.W., Jan. 6th, 1890.

To the Editors of THE LANCET.

SIRS,—The public interest in the wave of so-called influenza which is passing over so many parts of the globe is so great that I think you may like to give insertion to the following quotation alluding to the epidemic contained in a letter (dated Jan. 4th) which I have just received. The writer is one well known to our profession as a very able and accurate observer—viz., Dr. Bäumler, formerly assistant physician to the German Hospital at Dalston, and now Professor of Clinical Medicine and Director of the Medical Clinic at the University of Freiburg in Baden. Dr. Bäumler writes as follows:—

"It will perhaps interest you to hear that we also are in the midst of a severe epidemic of influenza, which, first commencing a fortnight ago, has now affected thousands of our population. My hospital wards are overcrowded, but so far the cases are of a mild type. The disease, however, looks somewhat different from the description generally given, the catarrhal symptoms in a great many cases being entirely absent. There is a sudden access of fever, the temperature in a few hours rising sometimes to 105° without any marked rigor, but accompanied by great prostration and headache; on the following or the second day the pyrexia goes down amid perspiration, and the patient may be convalescent. In almost all cases a slight enlargement of the spleen can be made out, and nearly all patients show a slight yellow discolouration of the sclerotic of their eyes; many of them also have a good deal of gastric disturbance—viz., vomiting in the very beginning, or diarrhœa. Cases with catarrhal affection of the throat and bronchial tubes are common enough, besides those above mentioned; and in some instances the catarrhal symptoms come out only during convalescence. There is no skin eruption of any kind."

Dr. Bäumler considers the disease to be highly infectious, as "many patients that were in the wards for other ailments were almost at once seized when a single case was admitted into the ward. This quite coincides with what your countrymen, Haygarth and Falconer, have made out in the last—and the beginning of this—century. It was probably the suddenness of the spreading which made it appear improbable that the disease spreads from the sick to the healthy by direct infection. The incubation period is evidently very short." Dr. Bäumler asks, "Why should there not be diseases with an incubation of only a few hours, when we know that in scarlatina also it may be less than a day? I think that the notion, or rather hypothesis, that the disease is due to a miasm is much more improbable than that it is a truly contagious disease."

In the above quotation I have accurately given the wording used by my correspondent. The general description of the epidemic, as seen in Freiburg by him, is very graphic, and certain features of the disease described have special value as regards the natural history of the disease. Especially to be noticed, I think, are the very rapid infection of patients observed in the wards, the exceedingly high temperature and absence of rigors, in some cases the enlargement of the spleen, and the absence or delay until convalescence of catarrhal symptoms met with in certain instances. I am not sure that present English opinion will support Dr. Bäumler in attributing the rapid spread of the disease so exclusively to "infection."

I am, Sirs, yours truly,

Cavendish-square, W., Jan. 7th, 1890. JOHN W. OGLE.

To the Editors of THE LANCET.

SIRS,—As it seems now certain that Londoners are to have their share of "the epidemic," I think it may be useful to employ a short time of enforced idleness in giving your

readers a description of it as it has come under my observation in this neighbourhood during the last ten days. I have called it "the epidemic" for want of a better term, as I cannot find any account of it in books or even in the daily journals which gives an adequate idea of the malady as I have seen it. I should describe it as an epidemic disease of a highly infectious nature, with a period of incubation varying from eight or ten hours to three or four days. Its advent is sudden, and commences with a sense of chilliness all over the body, quite distinct from the rigor of ordinary febrile attacks. This chilliness continues more or less throughout the attack, even during convalescence, if the patient be exposed to draughts. Immediately following this symptom, or coincident with it, the patient experiences severe pains of a dragging nature in the lumbar region, down the outside of the thighs, the anterior and posterior tibial region, and around the wrists and ankles, with intense pain over the cranium and frequently in the eyeballs (scierotic coat?), wherever, in fact, the tense fibrous tissues of the body occur. I have closely questioned patients as to the true location of these pains, and all assure me that they are quite distinct from the ordinary aching of the limbs and bones in a common cold. The catarrhal symptoms are principally confined to intense, hard, constant cough, with very little evidence of pulmonary trouble to account for its severity. If the gastric mucous membrane becomes affected, it is evidenced by complete anorexia, and sometimes vomiting, but under other conditions the appetite is rather increased.

The temperature of the body does not seem to be increased commensurately with the severity of the other symptoms. The highest record I have is 102·5°, which only lasted a few hours. The average is from 100° to 101·5°; prostration of strength is very marked. Convalescence seems to commence in about four days under favourable circumstances—viz., if the patient will keep to his bed, but there is a great tendency to relapses and more serious troubles if he persists in keeping about. I only propose to give an account of one family of cases, as they thoroughly illustrate all the observations I have made, and they have been confirmed by many subsequent instances.

A family consisting of father, mother, son, and lady visitor, went on Dec. 21st to dine with a gentleman just returned from Paris, said to be suffering from severe cold, "with such pains in his limbs that his doctor thought he was going to have rheumatic fever." Next morning (the 22nd), the son was seized with chilliness, and during the day coughed continually, and had great pain in his back and abdomen.

I saw him the following morning (Dec. 23rd) and found him constantly coughing, sitting up in bed, and groaning with pain in his back. A cough mixture with morphia relieved him, and next morning (the 24th) I found him up and dressed because his mother and the lady visitor (his *fiancée*) were ill. He was, however, still very poorly, and paid for his energy by a relapse which kept him in bed some days. The mother described her pains in the back and outer side of her thighs as agonising, as if all her sinews were being dragged out. The pain in her head was intense. The young lady's attack was less severe, and she refused to stay in bed, feeling pretty well after twenty-four hours. She had subsequently a formidable attack of acute sciatica, which yielded on the third day to salicine and poppy poultices. She afterwards had a second severe relapse of sciatica from getting up too soon. On the evening of the 25th a younger son, who had not been to the dinner, and the father were attacked. The son had a mild attack, but the father suffered most severely in the eyeballs.

The last case was that of a servant, to whom I allude only because she had previously had rheumatic fever, and suffered rather severely from pains in the fibrous tissues around the wrists and ankles, which she fully differentiated from the rheumatic pains. Moreover, the joints were neither red, swollen, nor immovable.

I think this series of cases is sufficient to establish my opening premisses—(1) That it is different from any epidemic of which we have any previous account, (2) that it is highly infectious, (3) that the pains are located in the tough fibrous tissues of the body, and (4) that it is quite unlike ordinary influenza, from the comparative absence of coryza.

Treatment.—Reasoning upon my view of the tissues involved, I soon began to treat the cases with salicylate of soda, giving ten grains with from three to five minims of tincture of aconite every three or four hours. I have invariably found relief after two or three doses, and frequently an entire subsidence of the pain. At night I have given ten to fifteen grains of antipyrin, but I have more faith in the salicylate when the pain is severe.

Diet I leave to the patient. If he is hungry, I tell him to eat, but I do not urge feeding when there is anorexia. I have not found stimulants beneficial until convalescence is fully established, nor do I find that convalescents can take large doses of quinine.

There is one more point with regard to infection to which I must allude. A gentleman subject to occasional severe "head colds" had an unusually severe attack after visiting at a house in which the epidemic, as above described, was in full force. He had no pains in his head, back, legs, or orbits. He had, however, slight bronchial catarrh, to which he was not subject. Four members of his family have since had the epidemic in its usual form, with severe pains in back, limbs, head, and orbits. Two young ladies who spent New Year's Eve at his house were attacked on the *following day*, and suffered rather severely. Did this gentleman get his coryza and catarrhal attack from the cases of that epidemic, and did he infect his family with it in the original form from which he took it? Are the two forms interchangeable?

I am, Sirs, yours truly,

ARTHUR J. CRIBB, M.D.Lond.

Highbury-place, N., January, 1890.

To the Editors of THE LANCET.

SIRS,—We have lately been visited at this port by the above epidemic, the first case in my practice having occurred about two weeks since. Since then I have had, in private practice, on an average twelve new cases a day. Amongst a regiment of Roumanian soldiers to whom I am acting medical officer I have also an average of six new cases a day. Amongst the British merchant steamers visiting the port my first cases occurred, and as the patients declared their illness on the passage from Constantinople I am of the opinion that the complaint came from there. The disease seems now to be increasing, and as it does so its symptoms, or complications, become more varied and severe. Some cases are ushered in mildly, with suffused eyes, headache, singing and noises in the ears, pains in the eyeballs, in limbs, joints, &c, fever, and catarrhal symptoms. These soon recover, and might be designated "true influenza"; others, on the contrary, are almost at once smitten with a severe dose of the poison, and become prostrate at once, and these cases have exhibited very anomalous and dangerous symptoms. In two cases of this class I had terrific epistaxis; in three, very severe gastric catarrh; in one, nephritis; in two, severe orchitis; in one, one-sided parotitis; in two, profuse hæmorrhage from the bowels, followed by mucous stools. In one a comatose condition of the patient lasted for two days; this was followed by gastric symptoms and double vision, which lasted thirty hours. In a child fourteen months old I witnessed a sharp attack of convulsions. The above are some of the principal bad symptoms I have met with, and certainly they are not the orthodox sequelæ of influenza. Of what, then, are they the complications? Some say we have the "dengue" amongst us. It may be so. But I have not seen one case as yet with an eruption. It is true we have, amongst the symptoms, severe joint and muscular pains of a shifting type, but I have never seen the scarlatiniform rash, or anything approaching to it, in these cases. I am so puzzled about the true nature of the disease that I leave the space in my visiting list for the insertion of the complaint vacant. I have seen a good deal of dengue in the West Indies, but certainly this, though it presents many symptoms in common with dengue, is not the dengue I can remember nearly thirty years since. Again, no one could attribute the very varied complications of this epidemic to simple influenza. Therefore, I say, we may safely ask, What is it?—I am, Sirs, yours faithfully,

A. IRWIN BOLTON, M.B, A.B., T.C.D.

Kustendjie, Doubrugha, Roumania.

To the Editors of THE LANCET.

SIRS,—The prevailing epidemic is invading this suburb, as it probably is others about London. Some twenty cases came under my observation yesterday, half of which had been under observation for some days previously. A remarkable fact was that nearly all of them were males.

The first person attacked in each house was invariably a male, and he in most cases went to London daily for his business, and in a few cases to establishments in the neighbourhood where large numbers of men are employed. Five females were seen suffering from the complaint, and in each house where they lived a male had developed the illness a few days before the females were attacked. The number of days intervening between the attacks was three to five.

The inference to be drawn seems obviously that the disease is contagious. Taken by the men in their places of business in London or elsewhere, it is conveyed to their homes in the suburbs, and the average period of incubation is four days—presuming that the disease only becomes communicable after the initial symptoms. Sudden chills, sometimes rigors, severe headache (mostly frontal and ocular), pains in the back and limbs, thirst and loss of appetite, much depression, and sometimes weakness were the symptoms. Slight sore-throat, coryza, and some cough were occasionally observed. Temperatures 100° to 103°; pulse frequent and generally weak; tongue coated and dryish. There seems to be a difference of opinion as to whether the disease is air-borne or contagious, and I submit these observations as they seem to point almost conclusively to the latter as being the correct inference. What I can hear corroborates my experience, and if observation is directed to the matter you may receive sufficient evidence to settle the point from other medical men who have the opportunity of wider experience. The fact of the joints not being involved and there being no rash preclude dengue. The early attack of the Diplomatic Corps and those places in closest communication with the countries abroad where the epidemic prevails is strong argument for the contagiousness of the disease.

I am, Sirs, yours obediently,

East Twickenham, Jan. 5th, 1890. H. HOWARD MURPHY.

To the Editors of THE LANCET.

SIRS,—Since Nov. 26th I have been daily treating cases of influenza. Varied as have been the symptoms, according to the idiosyncrasies of those attacked, yet there are certain symptoms common to all—viz., high temperature, 102° to 104°, muscular soreness, and subnormality of temperature on the fourth day usually. Influenza as seen by me here is then—fever, suddenly invading, quickly ending, without local lesion. It is not infectious, as yet, and seems to attack the well-to-do rather than the poor. Possibly influenza may present other symptoms in different parts of England. Rest in bed, free imbibition of effervescent waters, moderate doses of liquid food, have proved useful; and if the temperature kept high, small doses of acetanilide lowered it and produced perspiration, which relieved muscular soreness. One patient presented the peculiarity of having her temperatures higher in the morning than at night; this was also the case when she had typhoid fever and German measles.

I am, Sirs, your obedient servant,

Melksham, Wilts, Jan. 6th, 1890. S. GROSE.

To the Editors of THE LANCET.

SIRS,—Among the many conflicting opinions respecting the epidemic called "Russian influenza," allow me to add my mite of a suggestion as to its origin. This disease is evidently strange to the present generation; it is not, they say, the old-fashioned influenza, nor again the dengue. It must not be forgotten that many unusual earthquakes have occurred during the past year in Eastern Europe. Why should not this troublesome complaint have been produced by injurious emanations from the earth? Mild at first (contrary to the progress of most diseases), it gets worse as it goes on, apparently gathering up other morbific elements on its way. It reminds me of the results of certain earthquakes in New Zealand some thirty years ago, after which much sickness of a new and depressing nature broke out, especially in the Valley of the Hutt in the Province of Wellington. There is no more difficulty in admitting an atmospheric pollution travelling across the Atlantic to New York than that the red sunsets all round the world were lately caused by the dust of a Java volcano.

I am, Sirs, yours truly,

HENRY WEEKES, F.R.C.S.

Newport, Barnstaple, Jan. 2nd, 1890.

To the Editors of THE LANCET.

SIRS,—In your impression of the 21st ult., Dr. Bernard O'Connor stated that the periodate crystals (Weaver's) were very useful in ordinary influenza. During the prevailing epidemic I have used this drug in upwards of sixty cases, both locally, as recommended by Dr. O'Connor, and internally, with full doses of antipyrin. Its effects in cutting short the headache and burning pain behind the eyes is, in the majority of cases, simply marvellous. It appears to act in some of the cases out of the sixty that have been under my care at once or within an hour, and I have not had one under this treatment where the fever and aching pains in the limbs &c. failed to yield within thirty-six hours, while in most cases relief takes place in six or eight. Under the ordinary treatment with antipyrin alone the disease gives way more slowly.

I am, Sirs, yours faithfully,

B. G. GODFREY, M.R.C.S., L.R.C.P.

Devonshire Cottage, Balham, S.W.

To the Editors of THE LANCET.

SIRS,—Will you permit me, on behalf of the committee appointed by the Clinical Society of London to draw up a report on the duration of the periods of incubation and of infectivity in infectious diseases, to ask for notes of cases observed during the present epidemic which may throw light on the length of these periods in epidemic influenza? The transmission of this disease by infection has been denied, but it is probable that in a certain proportion of cases this is the effective means of propagation. Cases in which an attack has followed at a definite time after short contact with a previous case would be specially valuable, and it is possible that the earliest cases in a locality may afford evidence of this kind. Notes of such cases will be gratefully received by either of the hon. secretaries of the committee—Mr. Shirley Murphy, 41, Queen Anne-street, Cavendish-square, W., or

Your obedient servant,

DAWSON WILLIAMS.

25, Old Burlington-street, W., Jan. 8th, 1890.

To the Editors of THE LANCET.

SIRS,—Will you allow me to confirm the statement which I made in a previous letter as to the value of sulphurous acid in influenza? The cases which I have met with have been characterised by sudden invasion, severe headache, pains in the limbs, and a temperature of 103°. A few have had gastric disturbance. Very rarely have the symptoms begun with sneezing or coryza. The spray of sulphurous acid has invariably cut the disease short, and has prevented it from spreading in a house. Last week, after examining the chests of several patients in one house, in whom there was a very strong odour not unlike that given off in measles, I was in a short time attacked with violent sneezing and coryza. No patient would have liked to see me in that condition. By the free use of the spray in my rooms I was practically well in a few hours, and only had some conjunctival congestion, with swelling of the lids of one eye, the next morning. Two or three doses of salicylate of soda and the spray have made three patients practically well to-day in twenty-four hours.

I am, Sirs, yours faithfully,

Finchley-road, Jan. 7th, 1890. R. H. MILSON.

ANTIPYRIN AND THE PREVAILING EPIDEMIC.

To the Editors of THE LANCET.

SIRS,—Two years ago I made a communication to the Academy of Medicine, based upon a case which had occurred in my practice, where the most disagreeable effects had followed the administration of antipyrin. I quoted two other unpublished cases that had been related to me, and three published cases taken from English and American medical periodicals.

In the six cases the chief symptoms noted were: Three times swelling of the eyelids to such an extent that the eyes were almost closed; and swelling of the face, so that the features were scarcely recognisable. Once the swelling was chiefly located in the throat, and threatened asphyxia. Five

times there was a rash of some kind, generally erythema or urticaria, with troublesome itching. In one case where there was urticaria there was loss of consciousness; and, taking into consideration that it was immediately restored by the hypodermic injection of atropine, it seems to me quite possible that there may have been urticaria of the hemispheres, a rare but recognised condition. In two cases buzzing of the ears was noticed. In two also there was violent gastric pain, followed by gastro-enteritis, lasting six weeks, it being several months before the patient entirely recovered. Once there was profound mental disturbance, the patient being afraid of becoming insane, and the mental equilibrium did not return entirely for some months. Hypersecretion in the shape of running from the nose and eyes and excessive perspiration were noted several times, and once the patient felt as if she were stuffed with ice.

Although I had not been in the least alarmed by my patient, who had never been in the slightest danger, and only made known the case in the interests of truth, a somewhat sharp discussion followed, and a very eminent professor decided that his inexperienced *confrère* had been frightened at symptoms with which everyone was acquainted, referring to his *brochure* upon the subject where they were said to have been described. As a matter of fact, it was only mentioned that in some cases a rash appeared like that sometimes following the administration of quinine, but without gravity, and requiring no treatment—a very different picture to that which I had drawn. The same professor rallied me pleasantly upon what he was pleased to term my homœopathic tendencies in prescribing belladonna, supposing that I had done so on account of the "scarlatiniform" rash he had seen, whereas I was in reality guided in my choice by the fact that two of the commonest symptoms of an overdose of antipyrin being hypersecretion and urticaria, the drug that best counteracts these might reasonably be hoped to neutralise the effects of a medicine that gives rise to them. The upshot of the discussion was that a medicine having such high official approbation could on no account be allowed to have any kind of drawbacks.

Since then numerous cases have been related to me from time to time by people thinking that I was "against antipyrin," of which I have taken no account, using it neither more nor less than before. The only difference I have made since publishing my paper, which, I think, shows that the drug in question is not invariably harmless, has been to begin always by small doses of the drug. I generally prescribe the first full dose to be taken in four instalments, and when I have tested the idiosyncrasy of the individual, I continue henceforth with ordinary doses, always keeping a look out for possible accidents. I have several times had reason to congratulate myself that, instead of a tablespoonful containing ten or fifteen grains of the drug, I had begun with a teaspoonful every half-hour until the tablespoonful had been taken.

Now to the object of my present letter. During the last month or so I have been compelled, like everyone else, to give antipyrin for the treatment of the prevailing epidemic, my practice having consisted of a sharp purge to begin with, antipyrin to relieve the pain, and quinine as the specific remedy for the disease. In many cases there have been eruptions, some of which were pathological, but others were decidedly of drug origin. I have seen discharges from the eyes and nose, and swelling of the eyelids. The only serious complication of the disease of a preventable kind (bronchopneumonia and pleurisy having been generally due to imprudence) has been pulmonary paralysis, and, although I am wandering somewhat from the point, I have often found cough that had been attributed to bronchial irritation due to relaxed palate and uvula.

What I wish to point out, however, is that I find the symptoms put down to the influenza are in many cases those described in my paper as due to overdoses of antipyrin, particularly swelling of the eyes, urticaria, and watery discharges; and, conversing upon the subject recently with a member of the profession, I was told of a case terminating in death, and where, in my opinion, the fatal occurrence was distinctly due to treatment. The patient, an elderly American lady, had been treating herself. The symptoms had consisted of cough, a dusky eruption on the body, which appeared swollen, profuse perspiration, troublesome itching and urticaria, chiefly between the fingers, swelling of the eyelids, which were reduced to a mere slit, and fear of impending insanity. The antipyrin had been taken for about ten days, and persisted in, because the gravity of the symptoms, which included pains in the limbs and prostration, seemed to point to the necessity of active treatment. Finally, a medical man was called in and the antipyrin stopped, but the patient never rallied, and died two days later.

Antipyrin is one of the most valuable additions to the Pharmacopœia of modern times, and no one can call in question our indebtedness to it during the late epidemic; but I would submit that some of the supposed symptoms put down to the influenza are really due to the action of the remedy; and I feel sure that if the attention of the profession is called to this point, my statements will be endorsed by many others.—I am, Sirs, yours truly,

Rue Marbeuf, Paris, Jan. 1890. OSCAR JENNINGS, M.D.

A SENSITIVE AND CONVENIENT TEST FOR ALBUMEN IN URINE.

To the Editors of THE LANCET.

SIRS,—I have been for some years seeking a really trustworthy and, at the same time, convenient test for albumen in urine; and after a long series of experiments I am glad to be able to say that I think all the requirements of the busy clinical practitioner, as well as those of the more leisurely laboratory chemist, will be found to be satisfied by the trichloracetic acid introduced by M. Boymond in November last. This crystalline body can be carried in a small bottle, and all that is necessary to apply the test is to drop a fragment into a little of the urine in a test tube. There is no doubt about the reaction obtained, because the trichloracetic acid does not throw out peptones like the potassio-mercuric iodide, or coagulate mucin like so many other "tests." The white cloud caused by albumen is produced with distinctness when the albumen is present in only very small quantity, and it varies in density with the amount. Meanwhile, peptones are not, as I have said, deposited, and there is no need to counter-check the experiment by heat. It will be a great boon to practitioners to possess so delicate and trustworthy a means of recognising albumen in urine, with a test easily carried in the waistcoat pocket.

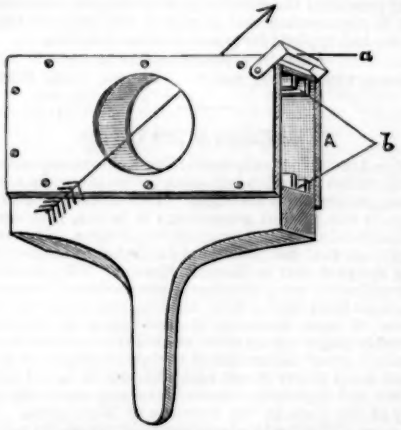
I am, Sirs, yours faithfully,

Hanover-square, W., Jan. 1890. J. MORTIMER GRANVILLE.

TESTS FOR COLOUR-BLINDNESS.

To the Editors of THE LANCET.

SIRS,—I see mention in a recent issue of THE LANCET of a test for colour-blindness by Mr. St. Clair Buxton, and gather therefrom that it is some test with coloured glasses.



a, Catch for holding glasses. *b*, Grooves.

For some time I have been testing the sight of my Midland Railway men with coloured glasses after the following plan:—I have a sort of flat box, with a handle below (*vide* diagram), the box being open at A and grooved along the

top and bottom to allow the glasses and a wooden slide to be inserted; it is not necessary to have the grooves, but is more agreeable. In the centre of both sides of the box is cut a hole 1½ in. in diameter, the box being large—6½ in. by 4½ in.—in order to shut out light from the side. I slide in, say, a red glass and a wooden slide having a diaphragm of $\frac{1}{16}$ in., and hold it up opposite an ordinary argand burner. The man to be examined stands four yards away. This now represents a signal lamp at a certain distance (*vide* table). By using wooden slides, with diaphragms of different sizes, I can estimate the man's vision for distance as well. Therefore, with a man four yards away, a light is seen through a diaphragm with

Diameter 1½ in.	representing an ordinary 6-in. railway signal	at	16 yards.
,, 1 in.	,, ,, ,,	,,	24 ,,
,, ¾ in.	,, ,, ,,	,,	32 ,,
,, ½ in.	,, ,, ,,	,,	48 ,,
,, ¼ in.	,, ,, ,,	,,	96 ,,
,, ⅛ in.	,, ,, ,,	,,	192 ,,
,, $\frac{1}{16}$ in.	,, ,, ,,	,,	288 ,,

I represent the appearance of fog by using a slide of ground glass, ground on one side only, increasing or diminishing the amount as the ground glass is in front of or behind the red. In actual practice I first use the $\frac{1}{16}$ in. diaphragm, and, as seen from the table, the light in this test is equal to an ordinary 6 in. railway lamp at 288 yards—a distance quite easy for any train to pull up in, and beyond any range of colour-blindness.

The Holmgren wools and the cavalry test I consider useless for two reasons: they are unscientific, and do not eliminate the possible factor of colour ignorance in the person examined.—I am, Sirs, yours faithfully,

Rotherham, Jan. 6th, 1890. F. B. JUDGE BALDWIN.

THE PROPOSED "PUBLIC MEDICAL SERVICE."

To the Editors of THE LANCET.

SIRS,—In reply to Dr. Carpenter, let me say that the report of the meeting of the Metropolitan Branch of the British Medical Association, which appeared in the *British Medical Journal* of Dec. 21st, 1889, is substantially accurate, though brief. Mr. Carpenter rightly says that the resolution, which he represented to have been passed, was an *amendment* to Mr. Nelson Hardy's resolution. Mr. Nelson Hardy's resolution, in a much modified form, was undoubtedly passed; therefore no amendment other than such modification can have been passed.

I am, Sirs, yours faithfully,

HUGH WOODS, M.D.

*** This correspondence must now cease.—ED. L.

MEAN DURATION OF LIFE.

To the Editors of THE LANCET.

SIRS,—Some discussion having arisen as to the method employed by me in estimating the mean duration of life in St. George's, Hanover-square, I wish to say that in 1876 and for several years subsequently I stated in my annual reports that my calculations were based upon Dr. Bristowe's formula for calculating the mean duration of life from the birth-rates and death-rates, as explained in his paper read before the Society of Medical Officers of Health in 1876, but for some years past I have not been in the habit of mentioning the formula by which the results were obtained. The formula is:—

$$x = \frac{\log. b - \log. d.}{\log. (1 + r.)}$$

Where x = Mean duration of life.
b = Birth-rate per unit of the population.
d = Death-rate per unit of the population.
r = Increase per unit of the population = $b - d$.

I never intended it to be inferred that I used the life-table method, but always expressly stated that the numbers were calculated *from the birth-rates and death-rates*. I may add that the numbers so calculated are approximately the same as those obtained by the formula, in which the reciprocals of the birth-rates and death-rates are employed, and that the figure obtained for the mean duration of life in the Mayfair subdistrict, which I quite admit is "phenomenal," is owing to the combination of an abnormally low birth-rate with an exceptionally low death-rate; while the difference between the figures for the Mayfair and Belgravia subdistricts, described as "incomprehensible," is easily explained by the fact that, while the death-rate of the latter is only 4 per 1000 higher than that of the former, its birth-rate is more than half as large again. Of course I quite agree that neither of the above, nor any other simple formula, gives the correct mean duration of life obtained only by the life-table method.

I am, Sirs, yours faithfully,

Savile-row, London, W., Jan. 8th, 1890. W. H. CORFIELD.

THE INFLUENZA EPIDEMIC.

THE real characteristic of the "Russian influenza"—viz., the rapidity of its dissemination among a population once it has gained a footing—has been fully exemplified in the metropolis during the past week. For whereas ten days ago we were noting only the occurrence of comparatively few cases, the numbers attacked since then have been extraordinarily high. The returns given below from various London hospitals furnish only a small part of the list of the sufferers, individuals in all classes of society, the *employés* of public institutions and large private establishments, business houses, &c. Several barracks have been invaded. So far, fortunately, the type of the affection here has been comparatively mild and singularly uniform in its characters—sudden onset, muscular and orbital pains, pyrexia of two or three days' duration, followed or accompanied by catarrh, but in only a small proportion by the more serious complications of pleurisy and pneumonia. In several cases an erythematous rash has been observed. The attack, even in its milder forms, produces a disproportionate degree of physical and mental prostration, which retards convalescence. The presence of the epidemic is noted in all parts of the country—from Portsmouth and Plymouth in the south, to Cardiff in the west, and Edinburgh in the north. In Birmingham it is especially rife. It has also appeared in Dublin, and every day brings information of fresh centres in the provinces; and if it follow the same course as it has done on the Continent, we fear it will be some time before we hear the last of it in this country. Indeed, abroad it is reappearing in places from which it had almost disappeared—such as Copenhagen. It is at last abating in Paris as at Berlin, but it is spreading in Italy, Servia, and Greece. From New York the latest information is that the epidemic is decreasing there. A remarkable piece of intelligence respecting it, which has its parallel in the records of earlier epidemics, is the account of its breaking out on board the Messageries Maritimes Company's steamer *Alphée*, on the voyage from Constantinople to Marseilles. The whole of the passengers and the greater part of the crew were affected, only six men and the captain being available to work the vessel.

The following statements from the different hospitals throughout the metropolis indicate the severity, and progress of the malady up to Thursday, the 9th inst.:—

Westminster Hospital.—At this hospital about twenty fresh patients are treated daily, and an average of about the same number are seen in the out-patient department. The disease here is of a comparatively mild type, and the invasion gradual in the majority of cases, although in some cases the patient is prostrated in a few hours. Shivering is generally more or less present in the severer cases, and bronchial irritation is almost invariable. The temperature averages 102°, and varies from 101° to 103°. Both sexes are attacked in equal proportion, and mostly between the ages of fifteen and forty years. Coryza does not seem common, but pains in the back and prostration, often so great as to render it difficult to foretell the period of perfect recovery, are the most unvarying features. The treatment here has

been quinine and compound tincture of camphor, a mixture which gives relief probably from the opiate it contains. Antipyrin seems to relieve the intense headache, and rest in bed is insisted on.

Charing-cross Hospital.—Fifty cases, including many of the hospital staff, have been attended as "casualties," and sixty or seventy in the out-patient department. The average temperature here is given at 101°; but in cases complicated with pleurisy it has risen to 104·2° and sometimes even higher. The age of most of the patients attacked is noted as being between twenty and thirty years.

University College Hospital.—Cases numbering 307 are recorded from this hospital, including many of the students and nurses, and a large number of out-patients. Four of the resident medical officers have been attacked, and the numbers treated as suffering from this epidemic are steadily on the increase. Five days ago the proportion of males to females attacked was as eight to one, but now the female cases seem to preponderate. Only 6 per cent. of cases were observed as occurring in children under ten years, whereas 84·5 per cent. of cases occurred in persons between ten and forty years of age. Shivering, loss of appetite, great pain at the back of the eyes and in the lower extremities, were most observable. In some cases there has been well-marked herpes, and in a few a patchy erythematous rash was seen on the face and arms.

London Hospital.—Only five or six cases of influenza pure and simple have been admitted to this hospital, and five or six with pneumonic symptoms, or with bronchitis as a result of the disease, while 1100 persons have called at the receiving-room suffering from the disorder.

Guy's Hospital.—The most striking feature at this hospital has been the mildness of the attack. As many as five of the sisters, twice that number of nurses, sixty to seventy students, and an average of eighty patients per day have been treated for the disease. Coryza was not observed except in very few cases, and one case is noted where an erythematous rash appeared. Rest in bed, light diet, and a tonic is the treatment relied upon.

Royal Free Hospital, Gray's-inn-road.—Of the 376 persons who applied for admission, only two were admitted, and thirty cases appeared among the patients already in the hospital. It has been found necessary to close one of the wards, as one-third of the nurses, three of the residents, and three of the visiting staff have been stricken with the complaint.

Middlesex Hospital.—At this hospital 431 out-patients have been treated, and eleven complicated cases have been admitted. An extensive rash was observed in one case complicated with pleurisy. The fever did not exceed 101° in ordinary cases, and severe aching pains in the head, lumbar region, and lower limbs were most observable.

King's College Hospital.—The disease was mild and generally uncomplicated. Nine cases were received into the hospital, four patients already in the hospital developed the symptoms, and fifteen of the nurses were attacked. A large and gradually increasing number of out-patients applied for relief.

St. Bartholomew's Hospital.—A large number of out-patients have been treated, but no uncomplicated case was admitted to the wards. The majority of the resident staff and a considerable number of nurses have suffered. No remarkable feature was observed in the four complicated cases now in this hospital.

St. Mary's Hospital.—Many of those employed about this hospital, and some few cases admitted in the ordinary way, in all forty-one cases, have been treated here for influenza during the week. The attack was usually very mild; only in five cases did the temperature rise to 103°–104°, and in five other cases to 104°–105°. All the cases have done, or are doing, well.

East London Hospital for Children.—During the current week twenty cases were seen in the out-patient department. Eight of the staff were attacked, but no definite case has occurred among the in-patients. Only six of the cases were under fourteen years of age, notwithstanding that an enormous majority of the patients seen here are under that age.

St. George's Hospital.—Four cases have been admitted into this hospital during the past week.

At the *Hospital for Sick Children*, Great Ormond-street, Bloomsbury, and in the *Belgrave Hospital for Children*, Gloucester-street, S.W., not a single child has been treated for influenza, either in the hospitals or among the out-patients.

We understand that in the Metropolitan Police, a force which numbers 14,000 men, where the average sick for this time of the year is from 400 to 500, the number on the sick list at present is about 1660. Of this number the large majority are suffering from the epidemic. Some of the attacks have been severe, but, contrary to rumour, there have been no deaths from the prevalent disease.

NORTHERN COUNTIES NOTES.

(FROM OUR OWN CORRESPONDENT.)

Alnwick.

THERE died at Alnwick on Jan. 3rd, in his thirty-seventh year, Mr. J. G. Donkin, a gentleman who, although not in the profession, was yet intimately connected with it. Mr. Donkin, being the eldest son of the late Dr. Donkin, who was many years a lecturer in the Newcastle school, and afterwards removed to London, where he practised some years in the West-end, and was noted for his advocacy of the treatment of diabetes by skim milk. The son, Mr. J. G. Donkin, was brought up to the profession, and attended some lectures, acting also as an assistant to the late Dr. J. C. Murray in Newcastle; but being of an adventurous and roving disposition and fond of travel, after a turn in the 12th Lancers as a trooper, his friends bought him out, and he joined the Carlists in Spain, where he saw some service, but his career was brought to an end by being taken prisoner with some other Englishmen, and they were conducted over the frontiers into France under parole not to take up arms again against the Spanish Government. Afterwards he joined the Canadian Mounted Police Force, and, being a daring and excellent rider, he soon became a special favourite with his companions. He saw much active service in Canada during Louis Riel's rebellion, and was present at the capture and execution of that notorious rebel. Mr. Donkin was an intelligent and highly educated man and possessed of considerable literary ability, as his published works of travel and adventure testify, amongst which may be mentioned, as his latest, "Trooper and Redskin in the Far North-West," and "Recollections of Life in the North-West Mounted Police," which last is likely to become popular, and has been recently published by Messrs. Sampson Low and Co.

Stockton.

The sanitary state of Stockton is far from satisfactory, and at the last meeting of the local board Dr. T. Watson, the medical officer of health, read a report on the prevalence of fever, which he thought indicated something very defective in the ashpit and cleansing arrangements. The Notification of Diseases Act came into force on Dec. 15th last, since which time thirty fresh cases of scarlet fever had been notified from twenty-three households, and also twelve cases of typhoid. The discussion of the matter by the board seemed to leave no doubt that the defective cleansing of the ashpits had much to do with the present insanitary state of the town.—On Monday last an inquest was held on the body of a young man who died, it was shown by the evidence of Mr. Flynn, in consequence of injuries received at a recent football match. The deceased was accidentally kicked in the abdomen, setting up inflammation, of which he died. Only a week or so ago I noted a similar death in the north. These cases are getting sadly frequent.

Deaths of Cumberland Practitioners.

I regret to note the deaths on the 30th ult. of two well-known Cumberland practitioners. Dr. Joseph Dickson died in Whitehaven, where he had been in practice many years. Dr. Dickson was an M.D. of Glasgow, L.S.A. Lond., and L.R.C.S. Edin.; he was consulting surgeon to the Whitehaven and West Cumberland Infirmary. Dr. Dickson, who was in his fifty-ninth year, has left a grown-up family, two sons being in the profession,—I believe, in practice in Whitehaven. Mr. Wm. Bowen Mathias, M.R.C.S., of Maryport, died there also on the same day in his sixty-third year. Mr. Mathias, who was for several years in active practice in Carlisle, had for some time practically retired,

but he still most considerately gave his services free to the sick poor, if unable to provide for regular medical attendance.

Sunderland.

At a committee meeting of the Sunderland and North Durham Eye Infirmary, conditional gifts of £500 were announced from the Backhouse family towards the new building fund, provided that a similar amount be raised for the purpose during the present year. The late Bishop Lightfoot left £100 to the Sunderland Infirmary.

Newcastle-on-Tyne, Jan. 9th.

EDINBURGH.

(FROM OUR OWN CORRESPONDENT.)

The Edinburgh Royal Infirmary.

AT a general meeting of the contributors to the Royal Infirmary, held on Monday afternoon, the annual report was read and remitted to a committee for examination. During the year ending Oct. 1st, 1889, 8606 patients were treated in the hospital, as compared with 8810 during the preceding year; 4866 were dismissed cured, 1932 relieved, 658 were dismissed on other grounds, and 552 died in the hospital, 598 being still in the institution on Oct. 1st. Of the 8008 cases that had passed out from the hospital, 3666 were ordinary medical cases, and 4342 surgical cases. The average daily number in the wards was 634, as against 639 last year; and the average time during which each patient was under treatment was 26·8 days, as compared with 26·3 days the previous year. The percentage of deaths of the whole of the ordinary medical and surgical cases treated was 6·4, or, without the 35 deaths that occurred within forty-eight hours after admission, 4·9. On an average 220 patients had attended daily (Sundays excepted) in the waiting rooms of the different departments, medical, surgical, and special. In 1889 the total cost of maintenance of each patient was £20 5*s.* 4½*d.*, and in 1888 £9 10*s.* 5*d.*, the total cost of medical attendance in the same years being respectively £7 17*s.* 8½*d.* and £7 10*s.* 5¾*d.* During the year over £30,000 have been received in the form of large donations and legacies; about the same sum was received as ordinary income, the total sum amounting to £61,051 8*s.* 3*d.* It is pleasing to note that there is an increase of the ordinary subscriptions amounting to £447 11*s.* 8*d.* The report from the nursing department was also satisfactory. That the nurses from the Training School are still in great demand is evidenced by the fact that of the sixty-eight trained nurses on the staff on Oct. 1st, 1888, twenty-two had left within the year. Although the vacancies to be filled up had thus been fewer than usual, the number of applicants desirous of joining the Training School exceeded that of any previous year since its establishment.

The University of Edinburgh.

The following statistics are taken from a report supplied to the papers at the beginning of the year. For the year 1889 the total number of matriculated students was 3602, as against 3532 in 1888, 2923 in 1879, and 1698 in 1869. Of this total, 981 were enrolled in the Faculty of Arts, 124 in the Faculty of Divinity, 472 in the Faculty of Law, and 2025 in the Faculty of Medicine. Of the students of medicine, 852 (or fully 42 per cent.) belong to Scotland; 735 (or over 36 per cent.) were from England and Wales, 50 from Ireland, 82 from India, 259 (or nearly 13 per cent.) from the various British colonies, and 47 from foreign countries. On the list of graduates for the year there appear two who took the degree of Doctor of Science, and 34 the degree of Bachelor of Science; and in the Faculty of Medicine 60 candidates graduated M.D., and 210 M.B. and C.M. The General Council, which under the new Act has such increased powers, now numbers over 6300 members. Those who have such dark forebodings for the future of the Scottish Universities can scarcely cull their facts from such reports as the one now before us. Edinburgh University was certainly never in a more flourishing condition than it is to-day, and with additional teaching power, a wider and more elastic curriculum in arts, and the many other important changes and innovations that the Commission can make, a still more vigorous existence may be safely prophesied for it.

The Royal Society.

At the meeting held on Monday, Dr. Alexander Bruce gave a paper on a hitherto undescribed connexion of the inferior olivary body with the medulla oblongata. He pointed out that the function of the olivary body had, from recent observations, been discovered to be concerned with the maintenance of the equilibrium of the body, and he stated how that opinion had been arrived at. It was evident from this that it would have important and wide connexions with other parts of the central nervous system, especially those parts which were known to have some function in the balancing of the body. Until quite recently only one of those connexions had been made out at all distinctly. It was recognised more from the investigation of pathological cases than from histological microscopic investigation that most of the fibres pass through the interior of one nucleus to another, some of them passing through, some behind, some of them anterior to the opposite olivary body, and then by way of the restiform body on the opposite side into the opposite hemisphere of the cerebellum. Dr. Bruce then explained the directions in which the fibres originated in the olivary body, and stated that recently, while making oblique transverse sections of the medulla oblongata, he had traced a track connecting the olivary body with the auditory nerve. The auditory nerve was divided into two portions, one directly connected with the sense of hearing and the other with the maintenance of the equilibrium of the body. That might be part of the reason why the olivary body had the same function as the auditory nerve. These observations will no doubt be published in full, and will be looked forward to with considerable interest by those who are working at nervous diseases.

The Influenza Epidemic.

Here, as elsewhere, there is great diversity of opinion as to the date of appearance and character of the new protean disease. Some say that it has been with us since Nov. 1st, and that the recent report of the Public Health Committee was founded on incomplete and erroneous information. There can be little doubt that the epidemic is now in full swing. The medical men report numerous cases, and many practitioners have been laid aside. It has made its appearance in the Law Courts, attacking no less a dignitary than Lord Wellwood. The postal and telegraph servants have been amongst the first to suffer, whilst the children in several of the Roman Catholic schools and the nuns in St. Catherine's Convent have been pretty generally attacked. Most of those here who have seen cases are of the opinion that many of them are far more like dengue than influenza, as the catarrhal symptoms are so frequently absent.

New Year's Day.

This year a new departure was taken with the closure of public-houses. It was recommended by the Chief Constable that all public-houses and licensed grocers should be closed on New Year's Day to see if the great amount of drunkenness and Hogmanay drinking could not be reduced. In consequence of this recommendation, 272 out of the 314 publicans and 388 out of 426 licensed grocers closed their houses and shops. Some of those who kept their premises open received so much custom and attracted so much attention, that they are likely to be warmly criticised when the licensing time comes round.

Edinburgh, Jan. 7th.

IRELAND.

(FROM OUR OWN CORRESPONDENTS.)

DUBLIN.

Infectious Disease (Notification) Act, 1889.

THE Dublin Corporation on Monday last passed a resolution that the Act should apply to Dublin. A considerable difference of opinion exists as to the desirability of the measure, and a large number of medical men regard it as unnecessary and objectionable. The Kingstown Commissioners have postponed consideration of the matter for three months.

The Epidemic of Influenza.

I think I may safely affirm that at least a hundred cases of influenza have occurred in Dublin, but it is satisfactory that up to the present the affection has been of a mild character, and although it is reported that a fatal case has taken place, I am of opinion that this statement is inaccurate. A case of a severe type of the disorder has been admitted into the Whitworth Hospital.

Royal College of Surgeons in Ireland.

Mr. Austin Meldon, President of the Royal College of Surgeons in Ireland, has sent out invitations to meet her Excellency the Countess of Zetland at a *conversazione* and concert to be held at the College on Saturday next, the 11th inst., at 4 o'clock.

Poisoning by Belladonna.

An out-patient of the Meath Hospital had a narrow escape last week. He obtained at the hospital a six-ounce bottle which contained nearly equal parts of linimentum belladonnæ and linimentum opii, with a little soap liniment. Although contained in a blue fluted bottle with two poison labels attached, the contents were swallowed, and on being admitted shortly afterwards to hospital the usual remedies were applied, but it was a considerable time before he was out of danger. The pupils the following day were extremely dilated, and had it not been for the antagonistic action of the opium it is most probable that death would have supervened. The exact quantity of belladonna taken is not accurately known, but the amount must have been considerable.

The Prevalence of Enteric Fever in Dublin.

Mr. Stirling of Dublin, an experienced architect and civil engineer, in a recent communication to the papers, draws attention to the inadequacy of the "so-called sanitary arrangements" in not only not preventing the spread of certain zymotic diseases, but also as a propagator of disease through the surface ventilators and untrapped sinks of our streets, areas, and yards. He is convinced that much of the present sanitary system is unsatisfactory in its working, as well as wrong in principle. He suggests a system of sewer ventilation which would not, like the present, retain about our houses and streets the sewer gases and fatal germs, but would draw them away and destroy them. Water carriage, while it is most wasteful, is the readiest and cheapest method for the removal of soil, but it fails to destroy or even remove the noxious gases and germs of disease; and Mr. Stirling suggests that these disease germs and sewer gases be induced to travel along the sewers to furnaces of intense heat placed at convenient distances, chiefly on high ground, in separate districts of the city; the furnaces to be utilised further for the incineration of the ashpit refuse, tipped into kilns at a heat of 1600° Fahrenheit, and converted into clinkers available for road metalling and concrete in the manner satisfactorily accomplished at Hornsey, Middlesex. All surface sinks and connexions, if any, with soil pipes, should be trapped; no trap to be placed between the house drain and the main sewer; no surface ventilators or other escapes for air to the streets, houses, yards, &c, but at the lower levels of the sewers air to be let in through tall shafts, continued well above the surrounding houses; the exit shafts or towers to be higher still, at least 150 ft. high. In these latter, at a height of about 70 ft., there should be chambers for the filtration through extremely corrosive chemicals of the ascending hot products of combustion.

Mr. John J. Donovan, J.P. of Skibbereen, died last week after a tedious illness, aged forty years.

Dublin, Jan. 7th.

BELFAST.

The Campbell Bequest.

The will of the late Mr. Henry Campbell has been exciting a great deal of attention in Belfast. This gentleman left property of the value of £200,000 in the hands of three trustees, to found a Campbell College for the education of the sons of Presbyterian and Episcopal clergymen, or a hospital, or both. The community of Belfast have formed themselves into two sections, one urging that the College scheme should be the one selected, the other the hospital. Mr. Campbell's partner in business, Mr. John Campbell, has written a temperate letter to the papers, pointing out the great need of further hospital extension, and showing that this would specially benefit the working classes who helped Mr. Henry Campbell to make his money. His suggestion is that the present Royal Hospital be kept for surgical cases, and that a new "Campbell" Hospital be founded and endowed for the treatment of consumptive patients and those suffering from ordinary medical diseases. The trustees met on Monday, and decided that, in accordance with the expressed wish of the late Mr. Campbell, they would first found and endow a college, and that any money left after doing this will be devoted to the establishment of a hospital.

The University Extension Scheme.

The opening address is to be given on Jan. 21st, by Professor Tyndall, on "Our Invisible Friends and Foes." Other lectures will be delivered by Professor Cunningham, M.D., on "How the Earth was Built, as the story is told by itself"; and by Mr. S. J. M'Mullan, on "Shakespeare: his Life, Times, Contemporaries, and Works"; and on "Representative British Writers, from Addison to Carlyle."

The Senate of the Royal University.

Chief Baron Palles has been elected a Senator in the room of the late Earl of Granard. It is expected that the Crown will appoint the President of Queen's College, Belfast, in Mr. Kavanagh's place. Owing to the death of the Rev. Dr. Delaney there is another vacancy in the gift of the Crown. The Convocation appointment will be filled up by the re-election of Dr. O'Sullivan of Cork, who is unopposed.

Queen's College, Belfast.

Mr. Hastings Crossley, M.A., who was appointed Professor of Greek in Queen's College, as successor to Dr. Chas. McDonall, has resigned after having occupied the chair for twelve years. It is said Mr. James McMaster, M.A., who was a very distinguished Queen's College student, will be a candidate. He is a Fellow of the Royal University, and at present Professor of Latin and Greek in the Magee College, Derry.

Influenza.

There is now no doubt that this epidemic has reached Belfast, several of the medical practitioners having had cases. So far the type of the disease is not very severe.

Belfast, Jan. 9th.

BERLIN.

(FROM OUR OWN CORRESPONDENT.)

Influenza.

THE first cases of influenza in Berlin were observed in the city hospital at Friedrichstein in the beginning of November. Very few of the numerous *employés* of the hospital, and only one of the previous patients (about a thousand in number), caught the disease. Most of the influenza patients in the Moabit Hospital were between twenty and thirty years of age. It is remarkable that not one of the inmates of a convent-like institution in Charlottenburg has been affected. They are all women, and are cut off with monastic rigour from intercourse with the outer world. Most of them have led a very chequered life, and many are predisposed to diseases, especially of the breathing organs.

The *Berlin Medical Weekly* of the 4th inst. contains the following description of the present, or immediately past, stage of the epidemic in Berlin: "So far as it is possible to base conclusions on personal experience and the statements of fellow-physicians, influenza seems to have abated somewhat in extent in Berlin within the last few days, whereas, in harmony with news from other places, cases in which deviations from the typical mild course of the disease occur are more frequent. In some of these the symptoms are severer from the first, both the nervous and the catarrhal or gastric disorders being more marked and lasting; in others, complications and secondary diseases, especially catarrhal pneumonia, occur; while in others—and this seems to be especially frequent—convalescence is interrupted by relapses, which often assume a more threatening character than the first attack. This is observed especially when patients expose themselves too soon to injurious influences (over-exertion, cold, mistakes in diet) before they are fully recovered. Cases, also in which the patients take the matter too lightly at first, often prove tedious, and consequently very weakening."

The death-rate was unusually high in Berlin in the Christmas week. The number of deaths was 1055, the second highest in 1889. The high summer death-rate in Berlin is due to cholera nostras and diarrhœa among children, but the present increase is among grown-up people. So high a death-rate in Berlin in December is not on record. Twenty persons died of influenza, 60 of bronchial catarrh, 151 of pneumonia, and 185 of consumption.

Influenza is rapidly spreading in Posen, and in many of the towns of the province of which it is the capital. Owing to its great frequency among children the Christmas holidays have been prolonged till the 13th inst. In Dresden the epidemic has been raging severely since Christmas, and many railway, post, and telegraph officials are off duty. The number of persons who went to congratulate the King and Queen on New Year's Day was about one-third less than usual. The Queen has the influenza, and was unable to be present. The Minister of Finance was absent for the same reason. In Munich, which was also spared till about Christmas, 70,000 people are ill of influenza, and an expert has calculated that the inhabitants of that city are drinking from 1000 to 1200 hectolitres of beer less than usual. The railway staff is sadly, if not dangerously, thinned, and several goods-trains have been temporarily stopped. Two of the most distinguished citizens, the great surgeon Nussbaum and the great theologian Döllinger, are on the sick list; and the latter, who is over ninety, is said to be in danger. Nussbaum is only sixty, but his general health is not robust. In Stuttgart, too, and the other chief towns of Würtemberg, the epidemic is raging, and in two cases in that capital it has terminated fatally, having developed in one case into pneumonia, in the other into cerebritis.

Professor von Bergmann.

Professor von Bergmann has now completely recovered from the severe attack of pneumonia from which he has been suffering for several weeks, and which he is said to have caught at Professor von Volkmann's funeral.

Death of Professor Botkin.

This eminent clinical lecturer in Russia died at Mentone on the 24th ult., aged fifty-eight. After the Crimean war, in which he took part, he studied in Germany and France under Virchow, Traube, Ludwig, Claude Bernard, &c. He has done much for the furtherance of medical science and education in his country. He was also an advocate of the higher education of women. A more questionable merit in all but Russian eyes was that, as medical adviser to the municipal authorities of St. Petersburg, he strove to remove all physicians and surgeons of German extraction from the hospitals of that city.

Professor Ferdinand Baumstark.

Dr. Ferdinand Baumstark, Professor of Chemistry at Greifswald, died there on Christmas Day, aged fifty. The themes of his writings are chloric acid, a crystallising formation in normal urine, the chemical composition of the substance of the brain, &c. He was the first to prove the presence of urofusiohæmatin and urorubrohæmatin in the urine of lepers. He has taught at Greifswald since 1866.

The Empress Frederick.

The managing committee of the Berlin Society for Domestic Hygiene has received the following autograph letter from the Empress Frederick, dated Naples, Dec. 6th, 1889: "The congratulations sent me by the managing committee of the Berlin Society for Domestic Hygiene on my last birthday gave me special pleasure far away from home. I thank the committee heartily for them. I gladly receive its vow faithfully to pursue the aims of our common work, and assure it for my part that it will be a consolation and life-task for me to go on labouring to the best of my ability in the field of publicly useful and beneficent works, as my dear consort, the late Emperor Frederick, wished and began.—Victoria, Empress and Queen Frederick."

Dr. Erwin Herter.

Dr. Erwin Herter, private lecturer in Berlin University, has gone to reside in Naples. He has taught medical chemistry here since 1881. His most important investigations had reference to the synthesis of sulphovinous acids and the effects of carbonic acid and the want of oxygen on animal organisms. In recent years he has devoted himself chiefly to hygienic studies.

Erratum.—In my last letter (page 56) the sentence ending the second paragraph should have concluded the first, and made to apply to Professor Koch's work on the "Biology of the Tubercle Bacillus," which is not expected to appear at present.

Berlin, Jan. 8th.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

AT a quarterly meeting of the Council of the College held on Thursday, the 9th inst., the minutes of the ordinary Council meeting of Dec. 12th, 1889, were read and confirmed.

It was agreed, on the recommendation of the Museum Committee, that the services of Mr. Burgess, the artist, be employed for a further period of six months, and that the Barnard Davis collection of skulls be mounted on stands.

It was agreed, on the recommendation of the Libraries Commiteee, that the Library be open to readers from this day until the quarterly Council held in January, 1891, on each weekday except Saturday, between the hours of 11 A.M. and 8 P.M. during ten months of the year, but that during August the Library be closed at 6 P.M., and be closed as usual during September.

The seventeenth report of the Committee on the Extension of the College Premises was read, adopted, and entered on the minutes. The committee have obtained from the architect detailed plans, according to which it is proposed to build the Museum with windows looking into Lincoln's-inn-fields, to take away the conservator's office, and to make a good entrance into the Museum at that point; and the committee recommended the Council to sanction the following estimates which they have obtained for the execution of this work: Cost of building, exclusive of fittings, £9443; cost of heating-apparatus for the new museum, £186 7*s.*; the museum hall, £72 16*s.*; and the front entrance hall, £54 18*s.*; a total of £9757 1*s.* With regard to the fittings for the new small museum, the committee recommend to the Council that a sum not exceeding £300 be devoted to the construction of pedestals with hinged leaves for the display of drawings in the upper gallery of the new small museum, and that the following expenditure be sanctioned:—Extra cost of putting mahogany railing-cases continuously round gallery, £51 6*s.* 6*d.*; three pairs of oak doors, £49 10*s.*

The secretary reported that one dissertation had been received on "The Pathology, Diagnosis, and Surgical Treatment of Intracranial Abscess and Tumour," the subject of the Jacksonian prize for the past year, bearing the motto, "*Lux in tenebris.*'

The President, Mr. Jonathan Hutchinson, was appointed Hunterian Orator for February, 1891.

A letter of the 23rd ult. was read from Dr. Liveing, registrar, reporting the proceedings of the Royal College of Physicians in reference to matters concerning the two Colleges.

It was agreed that in future, and in accordance with the proposed proceedings of the Royal College of Physicians, two Examiners in Public Health be nominated by the Nomination Committee, instead of by the Committee of Management, for election by the Council.

Mr. John Marshall, having resigned his appointment as member of the Committee of Management and of the Laboratories Committee respectively, Mr. Hulke was appointed a member of the former, and Mr. Power of the latter, in the vacancies thus created.

It is worthy of remark that eight members of the Council were absent, the majority on account of illness.

THE SERVICES.

ARMY MEDICAL STAFF.—Surgeon Henry Vincent Dillon, from half pay, to be Surgeon, vice W. B. Stokes, M.B., retired on temporary half pay; Sergeant-Major Joseph Beach, Medical Staff Corps, to be Quartermaster, with the honorary rank of Lieutenant, vice Honorary Captain A. Platt, retired; Surgeon-Major William Charles Gasteen, M.B., retires on retired pay; Surgeon Patrick James Barry O'Shaughnessy resigns his commission.

ADMIRALTY.—The following appointments have been made; Deputy Inspector-General Henry Hadlow to Haslar Hospital (dated Jan. 6th, 1890); Staff Surgeon Ludlow T. Colthurst to the *Penguin* (dated Jan. 14th, 1890); Surgeon Alfred H. L. Cox to the *Pembroke*, additional (dated Dec. 21st, 1889); Staff Surgeon Henry A. W. Richardson to the *Asia*, additional (dated Jan. 3rd, 1890); Mr. William E.

Redman to be Surgeon and Agent at Bridlington Quay; Surgeon William J. Maillard to the *Ganges* (additional), Surgeon Percy V. Jackson to the *Duke of Wellington* (additional), Surgeon Nicholas C. Ridley to the *Wildfire* (additional), Surgeon Elvington F. S. M'Kay to the *Duke of Wellington* (additional), and Surgeon Alexander Maclean, M.B., to the *Vivid* (additional) (all dated Jan. 1st, 1890).

VOLUNTEER CORPS.—*Artillery:* 1st Haddington; W. B. Macdonald, M.B., to be Acting Surgeon (dated Jan. 8th, 1890).—*Rifle:* 2nd East Yorkshire: Surgeon V. H. Fisher, M.B., resigns his commission (dated Jan. 8th, 1890).—1st Yorkshire: Alfred Barber, M.B., to be Acting Surgeon (dated Jan. 8th, 1890).—3rd Hampshire: Acting Surgeon A. V. Ford resigns his appointment (dated Jan. 1st, 1890).—Argyll and Sutherland Highlanders: Acting Surgeon T. A. Dickson resigns his appointment (dated Jan. 8th, 1890).—2nd (South) Middlesex: Acting Surgeon P. A. Murdoch, M.B., resigns his appointment (dated Jan. 8th, 1890).—1st Leicestershire: Surgeon C. F. Bryan resigns his commission (dated Jan. 1st, 1890).—3rd Hampshire: Acting Surgeon E. T. Crouch to be Surgeon (dated Jan. 1st, 1890).—The Highland Light Infantry: Nigel Stark, M.B., to be Acting Surgeon (dated Jan. 1st, 1890).—London Scottish: Surgeon-Major (ranking as Major) F. Matheson, M.D., resigns his commission; also is permitted to retain his rank, and to continue to wear the uniform of the Corps (dated Jan. 1st, 1890).—1st West Riding: Acting Surgeon T. G. Hall resigns his appointment.

VOLUNTEER MEDICAL STAFF CORPS.—London Division: Surgeon E. W. Willett, M.B., resigns his commission (dated Jan. 8th, 1890).

Obituary.

WILLIAM OSWELL LIVINGSTONE, M.B., C.M.GLAS.

WILLIAM OSWELL LIVINGSTONE, M.B., C.M., only surviving son of the great African explorer, and grandson of Robert Moffatt, the African missionary, died at his residence, Lattimore-road, St. Albans, at the early age of thirty-nine. He was born at Lake Ngami, South Africa, which his father had just discovered, and named after William Oswell, a celebrated elephant hunter, present with his father on the occasion, and now residing at Tunbridge Wells. He was sent to England at eighteen months, and returned to Africa at the age of seven for a year. He was sent to school in Hamilton, in Lanarkshire, whence he passed to the University of Glasgow to study medicine, and took his degree in 1874. He joined the Cameron expedition, but his health gave way, and he was obliged to remain at Zanzibar, where he met Stanley, who informed him of the discovery of Livingstone. He came to England with Stanley, and in 1875 received an appointment in Trinidad. He settled in London, but retired to St. Albans five years ago.

Among the relics of his father was a microscope presented by the Baroness Burdett Coutts, which he was very fond of working with. He presented Dr. Dunlop, medical officer of St. Pancras Workhouse, his old college friend, with a case of amputation instruments which had been used by the distinguished explorer in his earlier African travels. He took great interest in African affairs, and a week before his death dictated a congratulatory letter to Mr. Stanley, but he was too ill to finish it and it was not sent. He had an inherited passion for travelling, which the delicate nature of his health prevented him from indulging. He leaves a widow and a daughter.

PERCY RAVENSCROFT PONSFORD, M.R.C.S., &c.

BY the death of Mr. Ponsford, after a few days' illness at the South-Eastern Hospital on Dec. 31st last, another name has been added to the list of hospital residents who have fallen victims to diphtheria contracted in the performance of their duty.

Mr. Ponsford received his medical training at University College Hospital, where he was an assiduous student, devoting himself also much to athletic exercises. He was appointed clinical assistant at the South-Eastern Hospital in July last, and promoted to the assistant medical officer's post in November. In the performance of his duties he was most thorough and conscientious; he would not permit any considerations of personal convenience or comfort to stand between him and the faithful discharge of his duties. His straightforward and manly disposition rendered him a favourite with his colleagues and all who knew him, and his premature death at the age of twenty-four has deprived the profession of a man who would, from his professional knowledge, his earnestness of purpose, and fine character, have taken a high place in his profession.

Medical News.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—The following gentlemen, having passed the necessary examinations, were, at the quarterly meeting of the Council on the 9th inst., admitted Members of the College:—

Hobhouse, Edmund, St. Thomas's Hospital, Spring-gardens
Saunders, George Richard, St. Bartholomew's Hospital, Upper Gloucester-place.

MEASLES AT GOLBORNE.—Acting on the advice of the medical profession it was decided to extend the Christmas vacation with a view of suppressing the epidemic.

MEDICAL MAGISTRATE.—Mr. T. L. Ash, L.R.C.P., Edin., M.R.C.S. Eng., of Holsworthy, Devon, has been put upon the Commission of the Peace for the County of Devon.

NOTIFICATION OF INFECTIOUS DISEASES ACT.—At a meeting of the Sanitary Committee, held in the Guildhall to consider the subject of the notification of infectious diseases, a formal motion for the adoption of the Act was agreed to by the committee, including the medical officer.

THE Public Works Committee of Birmingham have lately been considering the desirability of improving the River Rea, and will, in all probability, recommend a scheme which will cost between £30,000 and £40,000, and which will prevent the insanitary accumulations which now collect in the stream as it now exists.

MEDICO-PSYCHOLOGICAL ASSOCIATION.—At the examination held at Bethlem Hospital, on the 19th and 20th ult., the following gentlemen passed and are entitled to the certificate in Psychological Medicine:—James Paton Boyd, M.B., C.M. Glas.; Hubert Carpenter Bristowe, M.B. Lond., M.R.C.S.; James H. Earls, M.D.; Francis Neel Gaudin, M.R.C.S., L.S.A. Lond.; Arthur Edward Patterson, M.B., C.M. Aber.; John James Pitcairn, L.R.C.P., M.R.C.S.; Arthur Price, M.R.C.S., L.S.A.; William Johnson Smyth, M.B., C.M. Edin.; Gilbert Henry Wickham, B.A. Camb., M.R.C.S., L.S.A.; and Mr. D. J. Williams.

DONATIONS TO HOSPITALS.—Mr. Edward Ecroyd, J.P., of Nelson, has given £500 for establishing a children's ward at the Victoria Hospital for Burnley and district. The gift was made through Mrs. Edward Ecroyd, who has taken great interest in the proposed ward. The chairman of the Windsor Royal Infirmary, Mr. F. T. Barry, has, in addition to his previous donation of £1000, made a further gift of £578, to be added to the balance remaining in the hands of the committee after building the new "Barry" accident ward, and effecting improvements in the out-patients' department, with certain instructions as to its investment.

GLASGOW ROYAL INFIRMARY.—The annual meeting of the governors and nurses of the Royal Infirmary was held on New Year's Day in the hall of the dispensary in connexion with the institution. Mr. William McEwan presided, in the absence of the Lord Provost, and was accompanied to the platform by a large number of notables interested in the hospital. The chairman pointed out that the origin of this annual meeting, instituted nearly a quarter of a century ago, was a desire on the part of the directors to improve the status of the nurses, and he thought that now no hospital could boast of a more efficient staff. He wished the nurses a happy new year and success in their work. Professor Gairdiner spoke of the excellent relations between the physicians and the nurses. The visitors were taken through the wards.

UNIVERSITY OF DURHAM COLLEGE OF MEDICINE, NEWCASTLE-ON-TYNE.—The gold medal for the best essay for the year 1889 has been awarded to Mr. F. W. Edridge-Green, the subject of the essay being "Colour-blindness."

PROPOSED ENLARGEMENT OF THE WARRINGTON INFIRMARY.—A scheme is under the consideration of the managers of the Warrington Infirmary for improving and extending the present building, and especially to provide a separate building for infectious diseases. The cost will be between £1000 and £2000.

GUY'S HOSPITAL NURSES.—Mrs. Lushington on Tuesday last presented silver medals to the sisters and nurses who have been for the past five years and upwards in Guy's Hospital. Mr. Lushington, who presided, said this was a new chapter in the history of nursing. Years ago they had no trained nurses, but only uneducated though kind-hearted women to do many menial tasks which the present nurses did not have to perform. That state of things had been altered by establishing grades, and by granting certificates to those nurses who had served a probationary period of three years. Nineteen medals were presented to sisters and nurses.

SOCIETY FOR THE STUDY OF INEBRIETY.—A quarterly general meeting of the Society for the Study of Inebriety was held on Tuesday, the president, Dr. Norman Kerr, in the chair. Mr. J. R. McIlraith, M.A., LL.B., of the Middle Temple, read an elaborate *précis* of the present state of the law relating to drunkenness and inebriety. A number of judicial charges were cited to show that the general tendency of our judges now is to accept as valid a plea of delirium tremens as entitling to criminal irresponsibility. Mr. Justice Stephen was adduced as distinguishing between ordinary drunkenness and disease secondary to intoxication. Among such secondary diseases the learned judge placed delirium tremens. Mr. McIlraith urged compulsory legislation for the reception and detention in curative homes of diseased inebriates.

POOR-LAW MEDICAL OFFICERS' ASSOCIATION.—At a meeting of the members, held at their rooms, 3, Bolt-court, Fleet-street, on Tuesday, Jan. 7th, in addition to other business, the following officers and council of the association were elected for the year 1890:—President: Sir Trevor Lawrence, Bart., M.P. Vice-presidents: D. B. Balding, F.R.C.S., J.P., Chairman of Council, and Robert H. Lloyd, M.D. Treasurer: C. M. Frost, F.R.C.S. Hon. Secretary: J. Wickham Barnes, F.R.C.S. Auditor: Walter Smith, M.D. Council: D. B. Balding, J.P. (Chairman); J. Wickham Barnes (Hon. Sec.); Dr. R. Fegan, Dr. A. Forsyth, C. Frost (Treasurer); Dr. Gayton, Dr. C. Gross, Dr. J. B. Gidley-Moore, Dr. R. H. Lloyd, W. Owen, H. W. Roberts, Dr. Walter Smith (Auditor); J. Milward Isaac Flower, Dr. W. Woodward, Dr. Sheen, Jas. Crocker, T. Walford, H. Stear, G. M. Evans, B. C. Gowing, E. P. King, Dr. Pearse, A. T. V. Packman, J. Bain Sincock, T. Sanders, and Dr. Martin O'Connor. The case of Mr. Stokes, of the Oundle Union, was further considered, and he was recommended to regard his present appointment as a permanent one.

METROPOLITAN ASYLUMS BOARD.

Return of Patients remaining in the several Fever Hospitals of the Board at midnight on January 7th, 1890.

Hospital.	Beds occupied.						Total accommodation.
	Scarlet fever.	Diphtheria.	Typhus fever.	Enteric fever.	Other diseases.	Total.	
Eastern Hospital	191	41	1	63	4	300	442
North-Western Hospital	201	25	..	11	..	237	415
Western "	188	11	..	18	..	217	262
South-Western "	140	..	..	..	..	140	350
South-Eastern "	248	16	4	22	5	296	462
Northern "	542	25	..	..	..	567	502
Totals	1510	118	5	114	9	1756	2523

Appointments.

Successful applicants for Vacancies, Secretaries of Public Institutions, and others possessing information suitable for this column are invited to forward it to THE LANCET Office, directed to the Sub-Editor, not later than 9 o'clock on the Thursday morning of each week for publication in the next number.

ARMITAGE, J. A., M.D. Edin., M.B., C.M., has been appointed Honorary Gynæcologist to the Wolverhampton General Hospital.

ARNOTT, JAMES, M.B., B.S. Durh., has been appointed House Surgeon to the Royal Infirmary, Newcastle-on-Tyne, vice S. J. Allden, M.B., resigned.

BLAKE, W. H., M.B. Lond., M.R.C.S., has been appointed Medical Officer for the Harpenden District of the St. Albans Union.

CROOKE, GEORGE F., M.D. Edin., M.R.C.S., L.S.A., has been appointed Lecturer on Practical Pathology at Queen's College, Birmingham.

DINGLEY, EDWARD ALFRED, M.D. Lond., M.R.C.S., has been appointed Assistant Surgeon to the West Bromwich District Hospital.

EDDISON, J. E., M.D. Edin., M.R.C.S., has been appointed Honorary Consulting Physician to the Leeds Hospital for Women and Children, vice Allbutt.

ELLIS, H. D., L.R.C.P. Edin., M.R.C.S., has been appointed Certifying Factory Surgeon, vice Ashmead, deceased.

HALE, E., L.R.C.P. Lond., M.R.C.P., has been appointed Junior House Surgeon to the Royal Southern Hospital, Liverpool, vice W. Croft Helme, M.B., C.M. Edin., resigned.

HARRIS, G. J., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the Anstey District of the Barrow-upon-Soar Union.

MCCANN, F. J., M.B., C.M. Edin., has been appointed House Surgeon to the West London Hospital.

MCILWAINE, S. W., M.R.C.S., L.R.C.P., has been appointed House Surgeon to Guy's Hospital.

MCNAIR, G., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the First Deddington District of the Woodstock Union.

MORTIMER, J. D. E., F.R.C.S., has been appointed Surgical Registrar to the Hospital for Sick Children, Great Ormond-street, vice R. C. Priestley, M.A., M.B., resigned.

MUIL, WILLIAM, M.D. Aber., M.B., C.M., has been reappointed Medical Officer for the Kirkby-Moorside Rural District.

NICKLIN, S., L.R.C.P., M.R.C.S. Lond., late Assistant House Surgeon to the General Hospital, Birmingham, has been appointed Resident Medical Officer to the Victoria Hospital, Burnley, vice J. F. Woodyatt, L.R.C.P., M.R.C.S., resigned.

NORBURN, A. E., M.R.C.S., L.R.C.P., has been appointed House Physician to Guy's Hospital.

SNELL, E. HUGH, M.B., B.Sc. Lond., M.R.C.S., L.R.C.P., has been appointed House Physician to the Queen's Hospital, Birmingham.

WATSON, J. R., M.B., C.M. Edin., has been appointed Medical Officer for the Harrogate District of the Knaresborough Union.

WILSON, G., L.R.C.P., L.R.C.S. Edin., has been appointed Medical Officer for the Redbourn District of the St. Albans Union.

WILSON, THOS., M.D. Lond., M.B., M.R.C.S., has been appointed Honorary Gynæcologist to the Wolverhampton General Hospital.

WINDLEY, WILLIAM, M.R.C.S., L.S.A., has been appointed Medical Officer for the South District of the Bingham Union.

WOLVERSON, THOMAS, L.R.C.P. Edin., M.R.C.S., has been appointed Medical Officer for the No. 2 District of the Wolverhampton Union.

WOODFORDE, W. T. G., M.D. Lond., M.B., has been appointed Analyst for the Borough of Newbery, Berks.

Vacancies.

For further information regarding each vacancy reference should be made to the advertisement.

BELGRAVE HOSPITAL FOR CHILDREN, 79, Gloucester-street, Pimlico.—House Surgeon. Board &c. found.

BOARD OF WORKS FOR THE ST. SAVIOUR'S DISTRICT. Offices: Emerson-street, Bankside, Southwark, S.E.—Medical Officer of Health. Salary £200 per annum.

BRISTOL EYE HOSPITAL.—Non-resident House Surgeon. Salary £120 a year.

BUCKINGHAMSHIRE GENERAL INFIRMARY, Aylesbury.—Resident Surgeon and Apothecary. Salary £80 for the first year, with an advance of £10 per annum until it amounts to £100, with board and lodging, washing, coal, and candles, in furnished apartments.

FISHERTON ASYLUM.—Assistant Medical Officer. Salary £100 per annum, with board, lodging, and washing. (Apply to Dr. Finch, Salisbury.)

GENERAL HOSPITAL, Birmingham.—Two Assistant House Surgeons for six months. No salaries, but residence, board, and washing will be provided.

HOSPITAL FOR WOMEN (the London School of Gynæcology), Soho-square, W.—Clinical Assistants both in the Out-patient and In-patient departments.

MANCHESTER CLINICAL HOSPITAL FOR WOMEN AND CHILDREN.—Honorary Aural Surgeon.

PARISH OF THE UNITED PARISHES OF WHITTLESEY.—District Medical Officer and Public Vaccinator. The salary as District Medical Officer will be £70 per annum, with the usual extra medical fees for Midwifery and Surgical cases, as prescribed by Order of the Local Government Board. The fees for vaccination and revaccination will respectively be 3s. and 2s. per case.

ROYAL HOSPITAL FOR DISEASES OF THE CHEST, City-road, London.—House Physician for six months. Salary at the rate of £50 per annum, with board and lodging.

TEIGNMOUTH, DAWLISH, AND NEWTON INFIRMARY AND CONVALESCENT HOME, Teignmouth.—House Surgeon (to act also as Secretary). Salary £40, with board and lodging.

Births, Marriages, and Deaths.

BIRTHS.

ARGLES.—On Jan. 5th, at Oxford-terrace, Hyde-park, W., the wife of Robert Argles, Surgeon, of a son.

BOURKE.—On Dec. 17th, at Poona, India, the wife of Surgeon-Major Ulick J. Bourke, Army Medical Staff, of a daughter.

BRUNTON.—On Jan. 2nd, at Stratford-place, W., the wife of T. Lauder Brunton, M.D., F.R.S., of a son.

GREENFIELD.—On Jan. 3rd, at Heriot-row, Edinburgh, the wife of W. S. Greenfield, M.D., F.R.C.P., of a daughter.

MACKAY.—On Dec. 27th, at Hornby, Lancaster, the wife of Ian D. Mackay, B.A., M.B., C.M., of a son.

MESSENGER.—On Dec. 30th, at Clairville, Rosslyn-hill, Hampstead, the wife of H. W. Messenger, L.D.S., of a son.

MOIR.—On Jan. 1st, at St. James-terrace, Great Western-road, Glasgow, the wife of W. Brown Moir, M.D., F.R.C.S., of a daughter.

OWEN.—On Jan. 4th, at Seymour-street, Portman-square, the wife of Edmund Owen, F.R.C.S., of a daughter.

WHITE.—On Jan. 7th, at Harley-street, the wife of W. Hale White, M.D., of a son.

MARRIAGES.

BONTOR—COLLS.—On Jan. 4th, at Holy Trinity, Barnes, by the Rev. G. J. Story, M.A., Vicar, Sidney Algernon Bontor, M.B., of Great Berkhamsted, son of Thomas Bontor, of Castelnau, Barnes, to Ada, eldest daughter of Lebbens Colls, of Castelnau, Barnes.

DICK—ROGERS.—On Jan. 4th, at St. Mary's, Hampton-on-Thames, William Dick, Surgeon, Medical Staff, H.M. Army, eldest son of James Dick, Esq., of Earlsferry, Elie, Fifeshire, N.B., to Mabel Charlotte Barrett, eldest daughter of Lieutenant-Colonel E. Rogers, Staff Officer of Pensioners, Canterbury.

FLETCHER—SMITH.—On Dec. 28th, 1889, at St. Mary's, Pembridge, by the Rev. J. Waltham Fletcher, M.A., father of the bridegroom, assisted by the Rev. F. Whitehead, M.A., Rector of Pembridge, and the Rev. W. G. Dimock Fletcher, M.A., F.S.A., Vicar of St. Michael's, Shrewsbury, and brother of the bridegroom, Charles William Corrie Fletcher, M.R.C.S., L.R.C.P. Edin., of Derby, to Florence Mabel, daughter of the late S. Pountney Smith, Esq., J.P., The Limes, Shrewsbury.

JAMESON—HENSMAN.—On Nov. 23rd, at St. George's Cathedral, Perth, Western Australia, Dr. Adam Jameson, fourth son of the late Rev. Charles Jameson, of Kirkcaldy, Fifeshire, to Ethel Mary, only daughter of Alfred Peach Hensman, of the Middle Temple, Barrister-at-law.

DEATHS.

ALLNATT.—On Jan. 7th, of congestion of the lungs, Richard Hopkins Allnatt, M.A., M.D., aged 86.

BEET.—On Jan. 7th, at Ashford, Kent, William Beet, M.D., aged 72.

BIRNIE.—On Dec. 31st, at Pevensey-road, St. Leonards-on-Sea, Thomas Knox Birnie, Deputy Surgeon-General (retired), aged 64.

BURY.—On Jan. 1st, at Park-side, Cambridge, Percy Bellamy Bury, M.B., C.M., late Surgeon R.N., aged 34.

COMBS.—On Jan. 6th, at Burwash, James Weston Combs, formerly Surgeon of that place, deeply regretted.

CRAWFORD.—On Jan. 4th, at Prince's-street, Port Glasgow, George Crawford, M.D. Glas., C.M., aged 54.

DANIELL.—On Jan. 7th, at Cathcart-road, South Kensington, Richard Thomas Daniell, M.B., F.R.C.S.I., only son of the late Surgeon Wm. Daniell, of Dublin.

DICKSON.—On Dec. 30th, at Lowther-street, Whitehaven, Joseph Dickson, M.D. Glas., L.R.C.S. Edin., aged 59.

HARRISON.—On Jan. 2nd, at The Mount, Higher Broughton, Manchester, James Bower Harrison, M.D. St. And., M.R.C.P. Lond., F.R.C.S.

MOORE.—On Dec. 10th, 1889, at Stony Hill, St. Andrew, Jamaica, Helen York, infant daughter of York T. G. Moore, L.R.C.P.Ed., M.R.C.S., aged six months.

STILES.—On Jan. 3rd, at Chippenham, Wilts, George Shield Stiles, Surgeon, aged 84.

WOOD.—On Jan. 6th, at Kirkby-Moorside, Yorkshire, Arthur Wood, L.S.A., Coroner for County York, aged 75.

N.B.—A fee of 5s. is charged for the Insertion of Notices of Births, Marriages, and Deaths.

Medical Diary for the ensuing Week.

Monday, January 13.

CHARING-CROSS HOSPITAL.—Operations, 3 P.M.
ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS.—Operations, daily at 10 A.M.
ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.—Operations, 1.30 P.M., and each day at the same hour.
CHELSEA HOSPITAL FOR WOMEN.—Operations, 2.30 P.M.; Thursday, 2.30.
ST. MARK'S HOSPITAL.—Operations, 2.30 P.M.; Tuesday, 2.30 P.M.
HOSPITAL FOR WOMEN, SOHO-SQUARE.—Operations, 2 P.M., and on Thursday at the same hour.
METROPOLITAN FREE HOSPITAL.—Operations, 2 P.M.
ROYAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.
CENTRAL LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M., and each day in the week at the same hour.
UNIVERSITY COLLEGE HOSPITAL.—Ear and Throat Department, 9 A.M.; Thursday, 9 A.M.
LONDON POST-GRADUATE COURSE (Royal London Ophthalmic Hospital, Moorfields).—1 P.M. Mr. Marcus Gunn: External Diseases of the Eye.
LONDON POST-GRADUATE COURSE (Hospital for Sick Children, Great Ormond-street, Bloomsbury).—4 P.M. Dr. Octavius Sturges: Acute Lung Affections in Infants and Young Children.
ODONTOLOGICAL SOCIETY OF GREAT BRITAIN (40, Leicester-sq., W.C.)—8 P.M. Election of Officers. Dr. Scane Spicer: On Nasal Obstruction and Mouth Breathing as Factors in the Etiology of Disorders of the Teeth.
MEDICAL SOCIETY OF LONDON.—8.30 P.M. Dr. J. Churton: Notes on an Epidemic of Pneumonia.—Mr. C. B. Keetly: Cases of Nephrolithotomy, and a case of Partial Nephrectomy for Injury.

Tuesday, January 14.

KING'S COLLEGE HOSPITAL.—Operations, 2 P.M.; Fridays and Saturdays at the same hour.
GUY'S HOSPITAL.—Operations, 1.30 P.M., and on Friday at same hour. Ophthalmic Operations on Monday at 1.30 and Thursday at 2 P.M.
ST. THOMAS'S HOSPITAL.—Ophthalmic Operations, 4 P.M.; Friday, 2 P.M.
CANCER HOSPITAL, BROMPTON.—Operations, 2 P.M.; Saturday, 2 P.M.
WESTMINSTER HOSPITAL.—Operations, 2 P.M.
WEST LONDON HOSPITAL.—Operations, 2.30 P.M.
ST. MARY'S HOSPITAL.—Operations, 1.30 P.M. Consultations, Monday, 2.30 P.M. Skin Department, Monday and Thursday, 9.30 A.M. Throat Department, Tuesdays and Fridays, 1.30 P.M. Electro-therapeutics, same days, 2 P.M.
LONDON POST-GRADUATE COURSE (Hospital for Diseases of the Skin, Blackfriars).—4 P.M. Mr. Jonathan Hutchinson: Psoriasis and Allied Diseases.
ROYAL MEDICAL AND CHIRURGICAL SOCIETY.—.30 P.M. Mr. Thomas F. Chavasse: Successful Removal of the entire Upper Extremity for Osteochondroma.—Mr. J. Cagney: The Mechanism of Suspension.

Wednesday, January 15.

NATIONAL ORTHOPÆDIC HOSPITAL.—Operations, 10 A.M.
MIDDLESEX HOSPITAL.—Operations, 1 P.M. Operations by the Obstetric Physicians on Thursdays at 2 P.M.
ST. BARTHOLOMEW'S HOSPITAL.—Operations, 1.30 P.M.; Saturday, same hour. Ophthalmic Operations, Tuesday and Thursday, 1.30 P.M. Surgical Consultations, Thursday, 1.30 P.M.
ST. THOMAS'S HOSPITAL.—Operations, 1.30 P.M.; Saturday, same hour.
LONDON HOSPITAL.—Operations, 2 P.M. Thursday & Saturday, same hour.
SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN.—Operations, 2.30 P.M.
GREAT NORTHERN CENTRAL HOSPITAL.—Operations, 2 P.M.
UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M.; Skin Department, 1.45 P.M.; Saturday, 9.15 A.M.
ROYAL FREE HOSPITAL.—Operations, 2 P.M., and on Saturday.
CHILDREN'S HOSPITAL, GREAT ORMOND-STREET.—Operations, 9.30 A.M.; Surgical Visits on Wednesday and Saturday at 9.15 A.M.
LONDON POST-GRADUATE COURSE (Hospital for Consumption and Diseases of the Chest, Brompton).—4 P.M. Dr. Theodore Williams: The Diagnosis of Pulmonary Tuberculosis.
LONDON POST-GRADUATE COURSE (Royal London Ophthalmic Hospital, Moorfields).—8 P.M. Mr. W. Lang: Ophthalmoscopic Cases.
SOCIETY OF ARTS.—8 P.M. Adjourned Discussion on Sir R. Rawlinson's paper on "London Sewerage and Sewage."

Thursday, January 16.

ST. GEORGE'S HOSPITAL.—Operations, 1 P.M. Surgical Consultations, Wednesday, 1.30 P.M. Ophthalmic Operations, Friday, 1.30 P.M.
CHARING-CROSS HOSPITAL.—Operations, 2 P.M.
UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M.; Ear and Throat Department, 9 A.M.
HARVEIAN SOCIETY OF LONDON.—General Annual Meeting, when there will be a Conversazione, and the President will deliver an address.
LONDON POST-GRADUATE COURSE (Hospital for the Paralysed and the Epileptic, Queen-square, Bloomsbury).—2 P.M. Dr. Howard Tooth: The Anatomy of the Medulla Oblongata and Spinal Cord.
LONDON POST-GRADUATE COURSE (Hospital for Sick Children, Great Ormond-street, Bloomsbury).—4 P.M. Dr. Octavius Sturges: Chorea and Allied Disorders.

Friday, January 17.

ROYAL SOUTH LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M.
LONDON POST-GRADUATE COURSE (Hospital for Consumption and Diseases of the Chest, Brompton)—4 P.M. Dr. Theodore Williams: The Diagnosis of Tubercular Excavation.
SOCIETY OF ARTS.—5 P.M. Mr. F. C. Danvers: The India Office Records.

Saturday, January 18.

MIDDLESEX HOSPITAL.—Operations, 2 P.M.
UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M.; and Skin Department, 9.15 A.M.
LONDON POST-GRADUATE COURSE (Hospital for Diseases of the Skin, Blackfriars).—2 P.M. Dr. Payne: Erythema, its Varieties.

METEOROLOGICAL READINGS.

(Taken daily at 8.30 a.m. by Steward's Instruments.)

THE LANCET Office, January 9th, 1890.

Date.		Barometer reduced to Sea Level and 32° F.	Direction of Wind.	Dry Bulb.	Wet Bulb.	Solar Radiation in Vacuo.	Maximum Temp. Shade.	Min. Temp.	Rainfall.	Remarks at 8.30 A.M.
Jan.	3	29·64	S.E.	35	34	..	44	32	..	Overcast
,,	4	29·70	S.W.	39	39	63	50	34	·13	Overcast
,,	5	29·77	W.	49	47	..	53	39	·12	Cloudy
,,	6	30·25	S.W.	51	50	..	55	48	·16	Raining
,,	7	30·36	S.W.	50	48	79	57	48	·00	Cloudy
,,	8	30·29	S.	50	49	56	51	49	.	Overcast
,,	9	30·30	S.W.	46	45	60	47	44	·11	Hazy

Notes, Short Comments, & Answers to Correspondents.

It is especially requested that early intelligence of local events having a medical interest, or which it is desirable to bring under the notice of the profession, may be sent direct to this Office.

All communications relating to the editorial business of the journal must be addressed "To the Editors."

Lectures, original articles, and reports should be written on one side only of the paper.

Letters, whether intended for insertion or for private information, must be authenticated by the names and addresses of their writers, not necessarily for publication.

We cannot prescribe or recommend practitioners.

Local papers containing reports or news paragraphs should be marked and addressed to the Sub-Editor.

Letters relating to the publication, sale, and advertising departments of THE LANCET *to be addressed "to the Publisher."*

We cannot undertake to return MSS. not used.

EARLSWOOD ASYLUM.

FROM a circular just issued by Dr. Robert Jones, Medical Superintendent of Earlswood Asylum, we extract a paragraph which may be of interest to many of our readers. We are frequently asked questions to which the subjoined statement will offer a reply.

> "The Board of Management, to meet a great want, have set apart certain suites of apartments in the asylum for the convenience and accommodation of harmless ladies and gentlemen, who receive all the benefits of medical treatment and supervision. Private patients are received at rates of payment varying from £1 5s. per week, according to accommodation required. Carriage drives, excursions, and temporary residence at the sea-side in care of attendants and nurses may be arranged upon specially agreed terms. At present there are over 150 private patients in residence."

Dr. Glasier.—Vierteljahrsschr. f. ger. Med. N.F., LI. 1., 1889; Schmidt's Jahrb., No. 11, 1889.

Manzoni.—We have taken note of our correspondent's letter.

THE APPOINTMENT OF DISTRICT MEDICAL OFFICERS.

To the Editors of THE LANCET.

SIRS,—The Local Government Board have sanctioned the appointment of a district medical officer residing out of the district, though three others reside in it. A protest was sent to the Local Government Board without any result. From the perusal of Glen's Poor-law Orders and the original Order of May 25th, 1857, this conduct seems to be illegal. I solicit an expression of opinion from some of your readers as to whether the conduct of the Local Government Board is legal, or if similar instances have occurred before.—I am, Sirs, yours truly,

January, 1890. RURAL.

LONDON MORTUARIES.

IN an annotation in last week's number on Mortuary Accommodation in London, by a clerical error we appear to express the hope that London sanitary authorities will defer the provision of mortuaries until the District Council Act for London has passed. It was our intention to express the hope that the fact that the local sanitary authorities would almost certainly await this measure before providing such accommodation would not escape the attention of the Government, and the opinion that for this and other reasons the introduction of the Bill should not be delayed.

Mr. John Tiernan.—We are glad to learn that our correspondent has seen his way to adopt our suggestion, and we hope that the result of the reference will prove satisfactory.

H. R.—Probably Ringer's Therapeutics would be the best for the purpose.

DISTIL COFFEE EXTRACT.

WITH reference to our notice last week of this extract, Messrs. Beare, Gosnell, and Co. write to call our attention to the fact that they manufacture two extracts of coffee, one of which—the one, indeed, which was the subject of our examination and remarks—is, to suit the taste of some coffee-drinkers, mixed with a small proportion of chicory, the other kind being pure coffee without any admixture.

Offa's Dyke.—We are not prepared to give advice as to the selection of such a club.

Mr. Havelock Ellis.—The paper will be inserted in an early number.

RE DR. FREDERICK MOON.—AN APPEAL.

To the Editors of THE LANCET.

SIRS,—In July last Dr. Moon of Greenwich, being misled by a false statement of a patient, passed a sound into a pregnant uterus. This was followed by septicæmia, peritonitis, and death of the patient. The coroner's jury returned a verdict of "Wilful murder," and Dr. Moon was detained in prison for three months (bail being disallowed), and tried at the October sessions of the Central Criminal Court. Although Drs. Barnes, Braxton Hicks, Galabin, Hayes, Peter Horrocks, M. Handfield Jones, and others were present, ready to give evidence for the defence, yet, without calling a single witness, he was fully acquitted by the jury, and Mr. Justice Stephen, before whom the case was tried, expressed his full agreement with the verdict. A large number of medical men of the locality gave testimony as to character. Three months' absence from practice and the heavy expenses of the defence, amounting to over £900, are a heavy penalty for a man who was pronounced innocent, and we, who have a full knowledge of the case, venture to appeal to the profession to assist in defraying the legal expenses. We, the undersigned, know Dr. Moon to be an upright and honourable man, and earnestly commend this case to our professional brethren. We are, Sirs, yours faithfully,

ROBERT BARNES, M.D., PETER HORROCKS, M.D.,
J. BRAXTON HICKS, M.D., M. HANDFIELD JONES, M.D.
ALFRED L. GALABIN, M.D.,

Dr. Horrocks (St. Thomas's-street, Southwark) has kindly consented to act as treasurer, and to receive subscriptions.

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THE SANITARY ACTS AND THE PUBLIC.

To the Editors of THE LANCET.

SIRS,—A short time ago you unearthed the power which every aggrieved person now enjoys of appealing direct to the local courts over the heads of the sanitary authorities. That privilege was obtained on my suggestion through Mr. Henry Bruen, then M.P. for Carlow. I had been ejected from my house for having complained of sanitary defects, and could get no redress from the sanitary authority. By the way, I was called on to apologise to them for calling them an insanitary authority, several deputy lieutenants and magistrates present having fallen into the notion that I accused them of being a mad board. It is strange that some of your medical contemporaries employ the incorrect work "unsanitary." I am, Sirs, yours faithfully,

Cashel, Dec. 20th, 1889. THOMAS LAFFAN.

DIPLOMA MILLS IN THE UNITED STATES.

THE *Boston Herald* devotes several columns to the exposure of bogus colleges in Vermont, New Hampshire, New Jersey, Ohio, and Montreal. A leading agent of the diploma business is called "Dr." Bradbury. His "mail" is said to be "frequently quite large," which "goes to show that the business is booming."

M.R.C.S.—Apart from such articles as can without damage be plunged into boiling water, we doubt the value of such preliminary processes as can be carried out in an ordinary room. If loose articles are properly collected and fastened up in a canvas sheeting before removal to the disinfecting station, no danger is known to result during the process of transference. Packing in tin boxes is not usual, and is not, as a rule, regarded as necessary.

COMMUNICATIONS not noticed in our present number will receive attention in our next.

COMMUNICATIONS, LETTERS, &c., have been received from—Dr. Seymour Taylor, London; Surgeon-General Marston, London; Mr. Christopher Heath, London; Dr. B. W. Richardson, London; Dr. Cutter, New York; Mr. E. Owen, London; Dr. Corfield, London; Mr. Jonathan Hutchinson, London; Dr. W. T. Gairdner, Glasgow; Dr. Hughlings Jackson, London; Surgeon-General Tuson, Brighton; Dr. Fletcher Beach, Dartford; Surgeon-General Gordon; Messrs. Anderson and Co., London; Mr. W. S. Richmond; Dr. Bays, London; Dr. Dawson Williams, London; Mr. S. F. Oldham, London; Messrs. Street and Co., London; Dr. Bird, London; Mr. F. Churchill; Messrs. Orridge and Co., London; Mr. E. B. Hastings, London; Messrs. Baillière and Co., London; Mr. A. Duke, Dublin; Dr. Corley, Dublin; Messrs. Lee and Martin, Birmingham; Mr. Parkam, London; Mr. E. E. Francis, London; Mr. J. Poland, London; Madame Wood; Mr. Johnstone, Durham; Mr. Hornibrook, London; Dr. Finch, Salisbury; Dr. J. W. Carr, London; Mr. Denman, Beaconsfield; Mr. W. J. Harris; Messrs. Debenham and Co., Cheapside; Dr. A. J. Bolton, Kustendje; Mr. R. Williams, Liverpool; Messrs. Blondeau et Cie., London; Mr. G. L. Johnson, London; Dr. T. H. Davies, Port Talbot; Dr. W. Squire, London; Dr. Maclagan, London; Dr. Beavan Rake, Trinidad; Dr. E. F. Neve, Kashmir; Messrs. Entwistle and Kenyon, Accrington; Mr. W. Hunting; Messrs. Beare, Gosnell, and Co.; Dr. Dunlop, London; Dr. Grose, Melksham; Messrs. Lee and Nightingale, Liverpool; Dr. H. F. Parsons, London; Messrs. Brady and Martin, Newcastle-on-Tyne; Dr. Cribb, London; Dr. Mortimer Granville, London; Dr. H. H. Murphy, Twickenham; Mr. Wickham Barnes, London; Dr. S. Di Giorgi; Dr. J. W. Ogle, London; Dr. Percy Duncan; Mr. Miller, Broseley; Dr. Gangitano, Naples; Dr. Norman Kerr, London; Mr. P. Thornton, Canterbury; Messrs. Richardson and Co., Leicester; The Earl of Meath, London; Messrs. C. J. Van Houten and Zoon, Holland; Mr. Weekes, Barnstaple; Mr. Spencer Watson, London; Mr. Biddle, Kingston; Messrs. Deighton, Bell, and Co., Cambridge; Mr. Dollar, London; Dr. H. Woods; Messrs. Down Bros., London; Dr. J. Taylor, London; Dr. J. F. Little; Dr. Bezly Thorne, London; Mr. Haslam, Birmingham; Mr. F. Moon; Dr. Oscar Jennings, Paris; Mr. F. R. Humphreys, London; Mr. N. A. Powell, Toronto; Mr. C. Mercier, Catford; Mrs. Delaforce; Dr. T. G. Lyon, London; Mr. Rayner, London; Mr. B. G. Godfrey, Balham; Dr. C. Read, London; Mr. Gerrard, London; Dr. Pope, Leicester; Dr. J. T. Graham, Perth; Mr. R. O'Callaghan, Carlow; Dr. Milson, Finchley; Dr. MacCombie; Mr. G. H. Ormsby, Slaidburn; Mr. Tweedie, Broadstairs; Dr. Hamilton, Hawick; Dr. McGowan, Maghera; Dr. Glover Lyon, London; Dr. F. P. Atkinson, Surbiton; Mr. Howe; Mr. Ernest Thomas, London; Mr. Alder, Chobham; Dr. C. Jecks, London; Dr. H. Cuff, London; Mr. R. Stuart, London; Dr. T. B. Beach, London; Mr. Ballard, Bournemouth; Mr. E. C. Stable, London; Mr. Greville, Edinburgh; Mr. Millar, Shropshire; M. Alcan, Paris; Mr. Overend, Anlage; Mr. Marten, Bolton; Dr. Champneys, London; Miss Boyd, co. Durham; Rev. A. Tooth, Croydon; Dr. Cripps, London; Mr. De Fraine, Aylesbury; Mr. Heaton, Bedford-park; Dr. Fletcher, Ormskirk; Dr. Murrell, London; Mr. Evans, Borough; Dr. Dickson, Glasgow; Dr. K. Pischl, Innsbruck; Mr. Carter, Southport; Mr. Hobott, Exeter; Mrs. Castle, Camberwell; Mr. Eskrigge, Royston; Dr. B. Squire, London; Mr. Skrimshire, Holt; Messrs. Pimms; Mr. Beal, Brighton; Mr. Coghill, Birmingham: Mr. Croke, Beverley; Mr. Cole, London; Messrs. Oppenheimer, London; Colonel Hallowes, London; Mr. Craven, Kendal; Mr. Moore, Liverpool; Mr. Phipps; Mr. Shera, Harrogate; Mr. Davies, Wrexham; Mr. Watt, London; Mr. Teegan, Manchester; Dr. Mason, Pontypool; Mrs. Levick, Paris; Mr. Budd, Cheshire; Mr. Furrell, Brighton; Dr. Spackman, Berks; Dr. Notter, Southampton; Mr. Radlauer, Berlin; Dr. White, London; Mr. Lyle, Dalston; Mr. Griffiths, London; Mr. Hugo, Reading; Dr. Milliagn, Manchester; Messrs. Johnston, Edinburgh; Mr. Haywood, Nottingham; Messrs. Maclehose, Glasgow; M.R.C.S.; C.; T. S. G.; Scrutator; C. S. H.; H. R.; One who was Present; Medicus Capensis; Sanitas Co., London; Belfast Ropework Co.; Offa's Dyke; Secretary, Wigan Infirmary; Secretary, Bradford Infirmary; Woodstock Union; Hospital for Women, London; One who hopes for better times; A. B., London; A., London; The Director-General of the Naval Medical Department.

LETTERS, *each with enclosure*, are also acknowledged from—Mr. Bonar, Bristol; Mr. Coulton, Devizes; Mr. Morton, Kent; Messrs. May and Baker, Battersea; Dr. Garnham, Rugeley; Dr. Cunninghame, New Zealand; Mr. Mackay, Hornby; Dr. Waters, Liverpool; Mr. A. de St. Dalmas, Leicester; Dr. Johnston, Dundee; Messrs. Hughes and Morris, London; Mr. Fiske, Tunbridge; Messrs. Wood and Co., New York, U.S.A.; Mr. Johnson, Monmouthshire; Dr. Hanson, South Hampstead; Mr. Bowlan, Newcastle-on-Tyne; Mr. Newbond, South Devon; Mr. Fleming, London; Mr. Crickmay; Mr. Gibson, Hebden Bridge; Mr. Williams, Cornwall; Mr. Redwood, Cardiff; Mr. Eyre, Monmouth; Mr. Heywood, Manchester; Mr. Pattin, Wolverhampton; Mr. Tully, Hastings; Mr. Dickson, Glasgow; Dr. Workman, Glasgow; Mr. Evans, Oswestry; Mr. Francis, Cardiff; Mons. O. Berthier, Paris; Mr. Tyte, Minchinhampton; Dr. Smith, Eccles; Dr. Mason, Monmouth; Dr. Highmoor, Guiseley; Dr. Largeau, Mort; Dr. Colman, London; Dr. Alyquid, Copenhagen; Mr. Thorn, Chorley; Mr. Baldwin, Stourport; Mr. Fletcher, Derby; Mr. Keetley, London; Mr. Ingham, Manchester; Dr. Hensley, Basingstoke; Mr. Williams, Ballymena; Dr. Maxwell, Woolwich; Mr. Brown, Tredegar; Mr. Sowerby, Jarrow-on-Tyne; Dr. Ogles, London; Dr. Bodger, Shildon; Mr. Smith, Reading; Mr. Dent, London; Mr. White, Glamorgan; Mr. Atkinson, Stockwell; Mr. Hay, Edinburgh; Dr. Leet, Liverpool; Dr. Blurton, Bristol; Mr. Packard, Ipswich; Dr. Hull, Allahabad; Mr. Bonter, Barnes; Dr. Reed, Queen's-gate; Dr. Shepherd, Usk; Mr. Martyn, Saltash; Mr. Stenhouse, Glasgow; Messrs. Chapman, Anthony, and Co., London; Mr. Rutson, Northallerton; Messrs. Maclachlan and Stewart, Edinburgh; Mr. Robbs, Grantham; Messrs. Bleasdale and Co., York; Mr. Gibson, Kent; Mr. Keer, London; Messrs. Back and Co., London; Dr. Ryan, Cork; Mr. Cochrane; Dr. Williams, Barry Port; Mr. Whittle, Liverpool; Mr. Pead, Whittlesey; Mr. Sanders, Tamworth; Mr. Barrett, Watford; Mr. Griffin, Walsall; Mr. Coote, Surrey; Dr. Lumley, Manchester; Dr. Grubb, Ealing; Mr. Connolly, Drogheda; Dr. Gibbings, Dalston; Mr. Davies, Rhyl; Mr. Deacon, Manchester; Dr. Cragg, Wick, N.B.; Mr. Hugo, Reading; Dr. Love, Belfast; Messrs. Duck, Cardiff; Mr. Cornish, Devon; Mr. Goodson, London; Mr. Johnson, Teignmouth; Secretary, Dartmouth; M.B., Essex; A. Z., Lowestoft; A. P. W., London; Medicus, Devon; The Levico Mineral Water Co., London; F. T., London; Verax, London; Lady Superintendent, Cambridge; Assistant, Southwark-park-road; Nurse Murray, Wallingford; Quietus, London; F. W. T., Liverpool; Nurse Lucy, Coldstream, N.B.; Fall, London; Permanency, London; M.D., Southsea; A. B., London; Medicus, Preston; Isa, London; M.B., Manchester; R. H., Stockport; W. T. B., London; B. G., London; Insanity, London; Medicus, London; Matron, Dorchester; Tom, London; A. H. D., London; X. Y. Z., London; Greatorex, London; Artius, London; L.R.C.P., London; H. & G., Chelsea; W. H. K., London; M.D., London; Sister, Ealing; K. L. M., London; D. P., London; Medicina, Birmingham; Mercury, London.

The County Council Gazette, Reading Mercury, Western Times (Exeter), Surrey Advertiser, West Briton and Cornwall Advertiser, Weekly Free Press and Aberdeen Herald, Agricultural Economist, Mining Journal, Spectator, Journal of British and Foreign Health Resorts, Hertfordshire Gazette, Stroud News and Gloucestershire Advertiser, The Herald (Melbourne), Daily Telegraph and Deccan Herald, Bath Argus, Liverpool Daily Post, Cape Times, Bath Herald, Glasgow Herald, Warrington Guardian, Trade, Finance, and Recreation, Child's Guardian, The Speaker, &c., have been received.

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